# Evaluation Guidance Handbook:

## Strategies for Implementing the Evaluation Guidance for CDC-Funded HIV Prevention Programs

March 2002

## Acknowledgments

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# Table of Contents

# Chapter 1: Introduction

## Purpose

This manual is intended to help health department staff implement the reporting requirements described in the Centers for Disease Control and Prevention's (CDC) Evaluating CDC-Funded Health Department HIV Prevention Programs: Volumes 1 and 2, June, 2001 [1] (i.e., the Guidance). It is intended to be a complement to the Guidance, not a substitute for it.

This manual describes various strategies that can be used by health departments to collect, analyze, report, and use Guidance data. These strategies reflect the collective experience and wisdom of health department staff gleaned during the first year of Guidance implementation. CDC acknowledges that there is no one way to implement the Guidance and developed this manual to help health department staff consider a variety of approaches to conducting Guidance activities. This manual is intended to stimulate health departments to enhance their current systems for implementing the Guidance.

## Using the Manual

It is not necessary to read this manual from cover to cover. Readers are encouraged to go directly to the issues of greatest interest to them and to explore other parts of the manual as needed. Numerous examples of data collection tools and other resources are described in the narrative and included in the appendix. Direct quotes from health department representatives are also included to illustrate some issues.

This manual focuses on those aspects of Guidance implementation that have been most challenging to health departments. Some chapters address challenges unique to specific Guidance reporting requirements while others focus on issues related to the Guidance as a whole. Evaluation of community planning and linkages with the comprehensive HIV prevention plan are not addressed as the Guidance has not established significantly new reporting requirements in these areas and few health departments have experienced substantive challenges with these requirements. Health departments should contact their CDC project officer if they need technical assistance in these areas.

A Note on Terms: Health departments use various terms to describe who they fund including vendor, provider, grantee, and contractor. For simplicity, the term "contractor" is used throughout this manual to describe the agencies sub-contracted by health departments to conduct HIV prevention interventions supported with CDC funds.

1 These documents are available for downloading from the Internet at the following address: http://www.cdc.gov/hiv/aboutdhap/perb/hdg.htm

## Manual Development

The process for developing this manual began with in-depth telephone interviews conducted with representatives from 15 health departments across a range of evaluation capacity as well as with staff from CDC, ORC MACRO, and the National Alliance of State and Territorial AIDS Directors (NASTAD). These interviews identified challenges and successes in implementing the Guidance, as well as strategies, methods, and systems that supported Guidance implementation. Data collection tools, reporting forms, and other resources developed by health departments were collected and reviewed. Issues identified through interviews and materials review were further explored during monthly conference calls with health department representatives and other stakeholders, including many individuals who did not participate in the first round of interviews. Further insight into challenges, successes, and resources related to the Guidance was gleaned during an affinity session on the Guidance convened at the Community Planning Leadership Summit for HIV Prevention held in Houston, Texas, in March 2001; and during expert panel meetings for two CDC studies to 1) assess the evaluation capacity of health departments and 2) assess the impact of the Guidance on health departments and their grantees. An initial draft of the manual was reviewed by representatives from eight health departments as well as staff from NASTAD, ORC MACRO, and CDC. Through these various mechanisms, a total of 27 health departments contributed directly or indirectly to the development of this manual.

## Limitations of the Manual

This manual is intended to help health department staff implement the Guidance and, therefore, does not describe strategies for conducting evaluation activities in excess of Guidance requirements.

Furthermore, the manual focuses specifically on those aspects of the Guidance that have posed the greatest challenges to health departments during the first year of implementation. It does not address all Guidance requirements and has minimized redundancy with the explanation of reporting requirements described in CDC's Evaluating CDC-Funded Health Department HIV Prevention Programs: Volumes 1 and 2, June 2001.

# Chapter 2: Guidance Overview

This chapter:

- Describes the purpose of the Guidance;
- Provides a brief overview of Guidance requirements;
- Summarizes the schedule for reporting Guidance data to CDC;
- Presents the CDC framework for HIV prevention planning, implementation, and results and shows its relationship to Guidance requirements; and
- Explains the limitations of the Guidance.

## Purpose of the Guidance

In December 1999, CDC released the Final Draft of the Guidance for Evaluating CDC-Funded Health Department HIV Prevention Programs (i.e., the Guidance). The Guidance was subsequently approved by the U.S. Department of Health and Human Services, Office of Management and Budget, and was released in its final form in June 2001. The Guidance specifies the types of evaluation data to be reported to CDC by health departments about their CDC-funded health department HIV prevention programs. Prior to the release of the Guidance, there were no systematic, standardized approaches to documenting and assessing the effects of HIV prevention efforts. As a result, evaluation findings were not comparable among health departments and not generalizable to the national level. With the Guidance in place, health departments and CDC can now employ common strategies and measures to document and interpret the varied and numerous programs they have funded and implemented. Specifically, the data reported to CDC will be used to report to federal, state, and local stakeholders (including community representatives, health departments, local and national organizations, and federal policymakers) progress made through HIV prevention programs supported by CDC funds; improve national policies regarding HIV prevention; and identify ways to improve HIV prevention programs.

It is important to note that the Guidance pertains only to HIV prevention activities supported with CDC funds and not all HIV prevention activities conducted within a jurisdiction. Similarly, the requirement applies only to CDC's health department grantees and their contractors, not to community-based organizations (CBOs) or other agencies receiving funds directly from CDC. A related Guidance has been created for these directly funded agencies.

## The CBO Guidance

CDC is currently developing guidance for directly funded CBOs that are conducting HIV prevention interventions (i.e., CBO Guidance). The CBO Guidance is similar to the Guidance for Evaluating CDC-Funded Health Department HIV Prevention Programs, but applies specifically to community-based organizations or other agencies receiving funds directly from CDC. Similar to the Guidance for health departments, the CBO Guidance specifies

intervention plan and process monitoring data to be reported to CDC. These data describe the CBO's and other agency's HIV prevention interventions and the characteristics of clients reached by those services.

There is one important difference between the two Guidance documents regarding how data are reported to CDC. The CBO Guidance directs agencies to report to CDC about their CDC directly funded interventions. The heath department Guidance directs health departments to report to CDC about interventions funded by the health department with CDC funds. Health departments aggregate data within the jurisdiction for reporting to CDC.

Within a jurisdiction, some contractors may receive direct funding from CDC as well as CDC funding through their health department. To avoid complications of dual reporting systems, the CBO Guidance was modeled on the health department Guidance so that data collection and reporting requirements are the same. For contractors receiving dual-funding for an intervention, data reported to their health department can also be reported to CDC to satisfy requirements of the CBO Guidance. However, if a contractor is receiving CDC funding for one intervention and health department funding for another, data on each intervention would be reported separately to each respective funding source. Health departments and directly funded CBOs within a jurisdiction are encouraged to share data with each other to improve the local planning and delivery of prevention services.

## Guidance Requirements

CDC divided the Guidance into two documents, Volume 1: Guidance, and Volume 2: Supplemental Handbook, to assist grantees in meeting both CDC's evaluation requirements and their own evaluation needs. Grantees are strongly encouraged to consult both documents when designing and implementing HIV prevention evaluation activities.

Volume 1: Guidance focuses solely on data collection and reporting required by CDC. Each chapter addresses one type of evaluation activity, including a description of the type of evaluation, a summary of CDC reporting requirements, a discussion of potential methods for collecting required data, and, when appropriate, an appendix containing sample data reporting forms.

Volume 2: Supplemental Handbook provides extensive information and suggestions for obtaining the minimum data requested by CDC and for conducting additional evaluation activities. Each chapter in the Supplemental Handbook corresponds to a chapter in the Guidance.

The Guidance describes health department evaluation and reporting activities in the following seven areas. These seven areas represent the minimum data required for collection and reporting to CDC. Health departments are encouraged to collect and use evaluation data in excess of these minimum requirements.

**Community Planning**: Evaluation of community planning does not specify any new reporting requirements beyond those discussed in CDC's Program Announcement 99004 for health department HIV prevention funding. These requirements include documenting implementation of the community planning process; completing the Profile of Community Planning Group Members to describe group member characteristics; and using the Table of Estimated Expenditures for HIV Prevention to describe HIV prevention allocations by intervention, population, and race/ethnicity. (For a comprehensive description of Community Planning evaluation reporting requirements see the Guidance, volume 1, chapter 2.)

**Intervention Plans**: An intervention plan sets forth the goals, expectations, and implementation procedures for an intervention and is often part of a proposal for funding. Intervention plans require that a core set of data elements be reported by the health department to CDC in the aggregate by type of intervention and risk population including: type of agency; number of clients to be reached, categorized by race/ethnicity and gender (except for health communication/public information [HC/PI] interventions); evidence or theory basis for the intervention; justification of the intervention for application to the target population and setting; and sufficiency of the service plan for implementing the intervention (For a comprehensive description of Intervention Plan reporting requirements see the Guidance, volume 1, chapter 3.)

**Process Monitoring**: Process Monitoring is the routine documentation of data that describe the characteristics of risk populations served, the services provided, and the resources used to deliver those services. Process monitoring requires that a core set of data elements be reported by the health department to CDC in the aggregate by type of intervention and risk population including: type of agency; number of clients served, categorized by race/ethnicity and gender (except for HC/PI interventions); number of full-time equivalent (FTE) staff used to provide the intervention; and expenditures for the intervention. Some intervention-specific implementation data are also required. (For a comprehensive description of Process Monitoring reporting requirements see the Guidance, volume 1, chapter 4.)

**Linkages**: Linkages examine the extent of congruence between the health department's comprehensive HIV prevention plan and its application to CDC for prevention funding, as well as the relationship between the comprehensive plan and the allocation of resources. Data to be reported include which recommended interventions in the plan are and are not included in the application and which funded interventions match and do not match the recommended populations and interventions in the plan. (For a comprehensive description of Linkages reporting requirements see the Guidance, volume 1, chapter 5)

**Outcome Monitoring**: Outcome monitoring assesses the extent to which an intervention achieved the expected outcomes. It does not, however, establish a causal relationship between the intervention and these outcomes. Health departments with at least $1 million in cooperative agreement funding from CDC are required to collect and report outcome data during the cooperative agreement for either an outcome monitoring or outcome evaluation project. Health departments that choose to conduct outcome monitoring are required, for the year 2002, to conduct this evaluation with at least 10 percent of their contractors who are implementing interventions appropriate for outcome monitoring. These data are to be reported in April 2003.

For the year 2003, health departments are required to conduct outcome monitoring with 20 percent of their contractors and report their findings in April 2004. Data to be reported include: names and affiliations of evaluators conducting the outcome monitoring; intervention type and goals; target population; evidence and justification for the intervention; copies of instruments and data collection tools; methods of data collection and statistical analysis; appropriate descriptive statistics, including client demographics; summary of findings; and how results will be used for program improvement. (For a comprehensive description of Outcomes Monitoring reporting requirements see the Guidance, volume 1, chapter 6.)

**Outcome Evaluation**: Outcome evaluation assesses intervention effectiveness in producing the desired cognitive, belief, skill, and behavioral outcomes within a defined at-risk population. Health departments with at least $1 million in cooperative agreement funding from CDC are required to collect and report outcome data during the cooperative agreement for either an outcome monitoring or outcome evaluation project. Health departments that choose to conduct outcome evaluation are required to evaluate at least one distinct HIV prevention intervention or set of integrated interventions by September 2003. Data to be reported include: names and affiliations of evaluators conducting the outcome evaluation; intervention type and goals; target population; evidence and justification for the intervention; evaluation design and methods; sample sizes for treatment and comparison groups and numbers of participants lost to attrition, as appropriate; copy of instruments and data collection tools; methods of data collection and statistical analyses; descriptive statistics, including client demographics; summary of findings (e.g., attrition, overall outcomes, and any subgroup analyses of differences due to demographics, features of the intervention, or other variables); and how results will be used for program improvement. (For a comprehensive description of Outcomes Evaluation reporting requirements see the Guidance, volume 1, chapter 7)

**Evaluation Plan**: An evaluation plan describes how the health department will implement the activities described in the Guidance. Information to be reported includes a description of how each of the Guidance reporting requirements will be met; how evaluation data will be collected, managed, and used; and the evaluation technical assistance needs for the jurisdiction. (For a comprehensive description of reporting Evaluation Plan reporting requirements see the Guidance, volume 1, chapter 8)

## Schedule for Reporting Guidance Data to CDC

The schedule below has been approved by the Division of HIV/AIDS Prevention - Intervention Research and Support. Each type of evaluation activity is reported annually, with the exception of outcome monitoring and outcome evaluation. Outcome monitoring data are due April 2003 and April 2004. Outcome evaluation is a single effort due in September 2003. Note that some annual due dates report data for the prior calendar year (i.e., retrospective) and others report projections for the next calendar year (i.e., prospective).

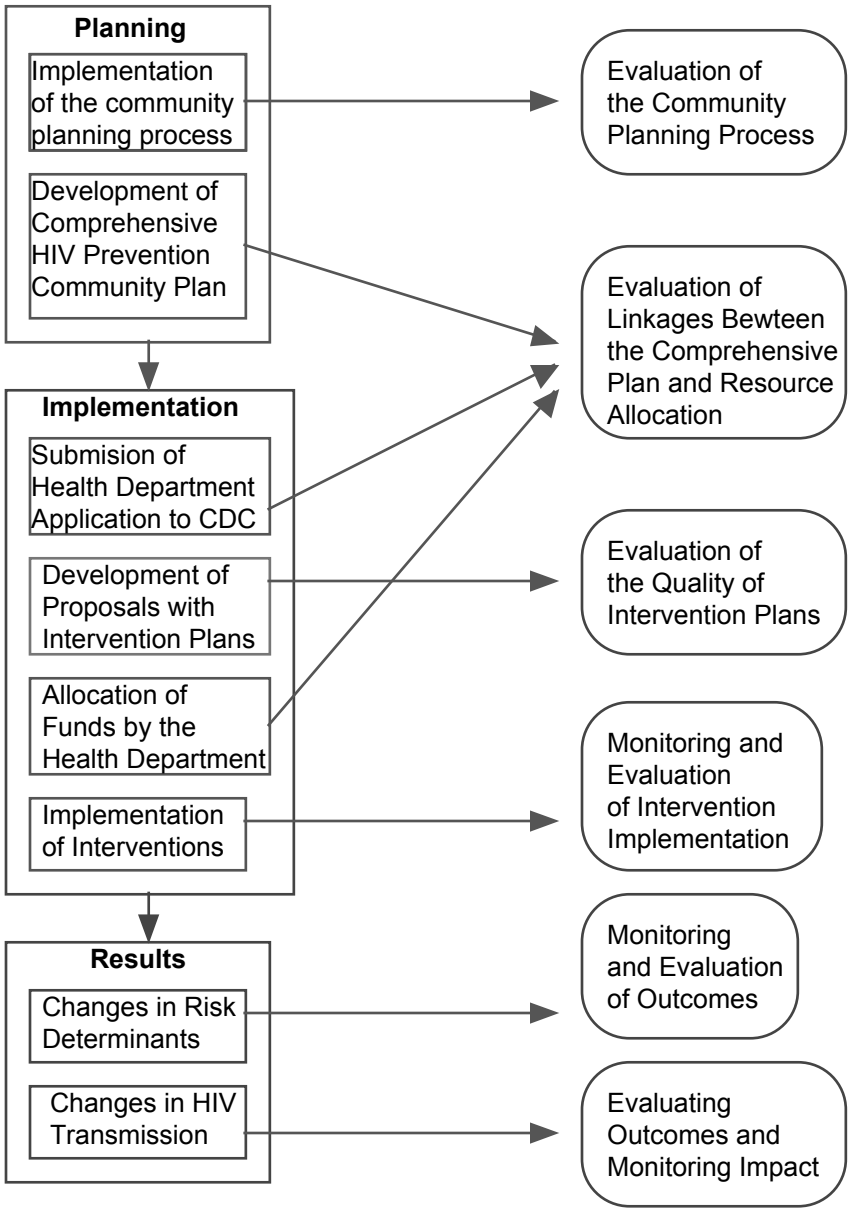
The Evaluation Guidance applies to HIV/AIDS prevention community planning and HIV/AIDS prevention programming carried out, in whole or in part, under Program Announcement 99004. Problems, issues, and concerns regarding time lines, due dates, and data submission should be discussed with CDC project officers.

| Schedule for Reporting Guidance Data to CDC | | |
|---|---|---|
| **Evaluation Type** | **Due Date** | **Reporting Period** |
| Community Planning Membership Grid (Guidance, chapter 2) | September (annually) | Members as of July 1 (retrospective) |
| Budget Tables / Tables of Allocations (Guidance, chapter 2) | April (annually) | January – December (prospective) |
| Intervention Plans (Guidance, chapter 3) | September (annually) | January – December (prospective) |
| Monitoring Implementation (Guidance, chapter 4) | April (annually) | January – December (retrospective) |
| Linkages between the Comprehensive HIV Prevention Plan and CDC Funding Application (Guidance, chapter 5) | September (annually) | January – December (prospective) |
| Linkages between the Comprehensive HIV Prevention Plan and Resource Allocation (Guidance, chapter 5) | April (annually) | January – December (retrospective) |
| Outcome Monitoring (Guidance, chapter 6) | April 2003 and April 2004 | January – December (retrospective) |
| Outcome Evaluation (Guidance, chapter 7) | September 2003 | Any time during the cooperative agreement |
| Updated Evaluation Plan (Guidance, chapter 8) | September (annually) | January – December (prospective) |

## CDC Framework for HIV Prevention

The evaluation activities addressed by the Guidance relate to CDC's conceptual framework for HIV prevention evaluation. This framework shows the relationship between HIV prevention planning, implementation of interventions, and the results of HIV prevention services. The framework is presented below, illustrating the relationship to each of the evaluation activities described in the Guidance.

**CDC Framework for HIV Prevention**




## Limitations of the Guidance

The Guidance describes evaluation activities as they relate to collecting and reporting data in keeping with CDC's Program Announcement 99004. Following are limitations of the required data and the information provided in the Guidance:

- The Guidance is not intended to provide information about how to conduct evaluation; rather, it is designed to assist grantees in responding to CDC requirements regarding the evaluation of HIV prevention interventions supported with CDC funds.

- The data that are collected through the implementation of Program Announcement 99004 comprise the minimum data set that CDC and its partners have agreed upon as sufficient for national evaluation purposes. Thus, that set of data does not constitute a comprehensive evaluation of all HIV prevention activities.
- The Guidance does not explain how health department grantees should use the data for program improvement; grantees should consult prevention program and evaluation staff, behavioral scientists and other experts, and evaluation texts for assistance.
- The Guidance provides guidelines for evaluating the basic characteristics of most, but not all, types of HIV prevention interventions. The types of interventions that are specified (see the Guidance, volume 1, chapter 3) are believed to account for the vast majority of HIV prevention interventions implemented throughout the United States.

## Chapter 3: Intervention and Population Definitions

This chapter:

- Reviews the Guidance definitions for interventions and populations;
- Presents strategies for reconciling differences between the Guidance definitions and local terminology; and
- Discuses strategies for reporting populations that are not defined by HIV risk behaviors.

### The Guidance Definitions

The Guidance establishes definitions for HIV prevention interventions and the behavioral risk populations they serve. The Guidance distinguishes between interventions that do and do not include skills-building activities because the development of HIV risk-reduction skills is an important part of interventions that lead to behavior change. With the exception of "Mother with/at risk for HIV" and "General Population," the Guidance uses HIV behavioral risk population categories because interventions are supposed to influence behaviors that transmit HIV disease.

These intervention and population definitions are used for reporting intervention plan and process monitoring data. By establishing definitions for use by all jurisdictions, the Guidance facilitates uniform reporting of evaluation data to CDC and can improve the clarity of communications within a jurisdiction.

> *"Probably one the biggest things that came to light with the Guidance definitions was that people weren't calling the interventions by the same name, both internally with our health department staff, as well as with our contractors, even though we had definitions and standards in place." Health Department Staff Member*

Each aggregate intervention plan and process monitoring data report consists of descriptive data for one of seven interventions provided for a specific population in a jurisdiction. The interventions and populations and their definitions are presented below.

| **Intervention Definitions** | | |
|---|---|---|
| **Intervention** | **Definition** | **Excludes** |
| Individual-Level Intervention (ILI) | Health education and risk-reduction counseling provided to one individual at a time. ILI assists clients in making plans for individual behavior change and ongoing appraisals of their own behavior and includes skills building activities. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. | Outreach and prevention case management. Each intervention constitutes its own category. Also excludes HIV counseling and testing which is reported in a separate category using the standard bubble sheets. |

| Intervention Definitions | | |
|---|---|---|
| **Intervention** | **Definition** | **Excludes** |
| Group-Level Intervention (GLI) | Health education and risk-reduction counseling (see above) that shifts the delivery of service from the individual to groups of varying sizes. GLI uses peer and non-peer models involving a wide range of skills, information, education, and support. | Any group education that lacks a skills component (e.g., information only education such as "one-shot" presentations). These types of interventions should be included in the HC/PI category. |
| Outreach | HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the neighborhoods or other areas where they typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Includes peer opinion leader models. | Condom drop offs, materials distribution, and other outreach activities that lack face-to-face contact with a client. |
| Prevention Case Management (PCM) | Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage. | One-to-one counseling that lacks ongoing and individualized prevention counseling, support, and service brokerage. |
| Partner Counseling and Referral Services (PCRS) | A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services. | HIV counseling and testing which is reported in a separate category using the standard bubble sheets. |

| Intervention Definitions | | |
|---|---|---|
| **Intervention** | **Definition** | **Excludes** |
| Health Communication/ Public Information (HC/PI) | The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services.<br><br>Electronic Media: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city-, region-, or statewide) audience.<br><br>Print Media: These formats also reach a large-scale or nationwide audience and includes any printed material, such as newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage.<br><br>Hotline: Telephone service (local or toll-free) offering up-to-date information and referral to local services (e.g., counseling/testing and support groups).<br><br>Clearinghouse: Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide a responsive information service to the general public as well as high-risk populations.<br><br>Presentations/Lectures: These are information-only activities conducted in group settings; often called "one-shot" education interventions. | Group interventions with a skills-building component, which constitutes a separate intervention category. |

| Intervention | Definition | Excludes |
|---|---|---|
| Other | Category to be used for those interventions funded with CDC Program Announcement 99004 funds that cannot be described by the definitions provided for the other six types of interventions. This category includes community-level intervention (CLI).<br><br>CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions. | Any intervention that can be described by one of the existing categories. |

| **Population Definitions** | | |
|---|---|---|
| **Population** | **Definition** | **Exposure Route and Risk Behaviors** |
| MSM | HIV prevention needs of men who report sexual contact with other men or with both men and women. | Unprotected sex between men that results in exposure to semen or blood. |
| MSM / IDU | HIV prevention needs of men who report both sexual contact with other men and injection drug use. | Risks through both unprotected sex with other men and injection drug use that results in exposure to semen or blood. |
| IDU | HIV prevention needs of people who are at risk for HIV infection through the use of equipment to inject drugs (e.g., syringes, needles, cookers, spoons). | Use of needles, syringes, or preparation materials by two or more people that results in exposure to blood. |
| Heterosexual sex with someone at risk for or infected with HIV | HIV prevention needs of persons who report specific heterosexual contact with a person with, or at increased risk for, HIV infection (e.g., sex with an IDU, a bisexual male, or a person known to be HIV-positive or to have AIDS). | Unprotected vaginal, anal, or oral sex between a man and woman that results in exposure to semen, vaginal fluids, or blood. |

| Population | Definition | Exposure Route and Risk Behaviors |
|---|---|---|
| Women who are at risk for or infected with HIV who are pregnant | HIV prevention needs of women who have HIV or are at risk of becoming infected and who are pregnant or at risk of becoming pregnant and, thus, at risk of transmitting HIV to their infant. | Transmission to the baby prenatally, during delivery, or through breast-feeding. |
| General population | Intervention will not be targeted to any specific groups whose behavior puts them at high risk for HIV infection. | No specific risk for HIV, but often the target of broad prevention or education efforts to increase awareness or change community norms. |

## Reconciling Differences between Guidance Definitions and Local Terminology

Some jurisdictions defined their populations and interventions prior to the release of the Guidance, consequently, these definitions may differ from those found within the Guidance. Examples of locally defined populations include youth, women, crack users, African Americans, homeless persons, incarcerated persons, people living with HIV, and other groups not explicitly defined by a behavior that increases one's risk for HIV exposure or transmission to others. In the absence of a specified HIV-risk behavior, these populations do not match the Guidance definitions for populations. Similarly, local intervention definitions and Guidance definitions may differ (e.g., contractors may consider a "home party" to be a GLI even if it does not include a skills-building component).

Differences between Guidance definitions and local terms may cause health department staff and contractors to feel that some populations and interventions have been excluded from the Guidance. It is important to emphasize that the Guidance does not require health departments to replace local terms that have already been established in the jurisdiction. However, health departments must be able to translate local terms to match the Guidance definitions for reporting to CDC so that a national standardized data set can be created and maintained.

Reconciling differences between local terminology and Guidance definitions is an important step in developing a system for gathering and reporting Guidance data. Health departments commonly use three different strategies for reconciling these differences:

- Contractors use local terms,
- Contractors use Guidance definitions, and
- Contractors use both Guidance definitions and local terms.

**Contractors Use Local Terms**

Health departments allow their contractors to continue to use local population and intervention terms and to report data to them using this language. These data are then recoded by the health department to match the Guidance definitions for reporting to CDC.

Example: A target population might be reported to the health department as "crack users" and then recoded and reported by the health department to CDC as targeting "heterosexuals", if that is the predominant HIV risk behavior exhibited by this population. Likewise, a series of "home parties" with a skills-building component may be recoded as a GLI.

Health departments are encouraged to work closely with their contractors to understand how local definitions are used and to develop a systematic way to recode data consistent with Guidance definitions. Recoding of local population and intervention data can be done manually or can be facilitated by data management software. Software can be programmed to allow data entry using local terms and then automatically recode the data according to how the health department has decided to report these populations and interventions to CDC.

> *"We tried asking people to conform to the Guidance definitions and we know that didn't work. Now we're going to use their own terminology and use the computer to do all of that work internally to translate the data to the Guidance terms. So when we program our data entry system that's how we'll set it up." Health Department Staff Member*

**Contractors Use Guidance Definitions**

Health departments expect their contractors to adopt the Guidance definitions and to use these terms exclusively. Health departments often collaborate initially with their contractors to clarify the relationship between the Guidance definitions and local population and intervention terms.

Example: A jurisdiction may decide that interventions targeting "youth" will be reported as reaching two Guidance populations: "heterosexual" and "MSM." Similarly, the activities of a speakers' bureau formerly reported by contractors as "risk-reduction sessions" may now be reported as "HC/PI."

Once the relationship between local terms and the Guidance definitions has been clarified, the health department may need to provide ongoing assistance to contractors during the transition to using the new definitions. Population and intervention definitions can be incorporated into paper data collection forms and data entry screens to reinforce proper use of the definitions and to facilitate accurate reporting.

**Contractors Use Both Guidance Definitions and Local Terms**

Health departments expect their contractors to adopt the Guidance definitions but also allow them to use local population and intervention terms. For populations, contractors report data

using the Guidance definitions and also select one or more locally defined terms to further describe the population (e.g., heterosexual homeless person living with HIV).

Likewise, intervention data can be reported using Guidance definitions paired with local intervention terms (e.g. GLI risk reduction party). The simultaneous use of local and Guidance terms can be facilitated by data management software. Data entry screens can display local terms linked to data entry fields that prompt reporting using the Guidance definitions.

**Summary**

Health departments are encouraged to consider the advantages and limitations of these three strategies as they develop systems for collecting and reporting Guidance data in their jurisdiction. Contractors' exclusive use of locally defined population and intervention terms avoids the challenges of establishing a new set of definitions and may retain consistency with language already used by local planning and service delivery groups (e.g., HIV prevention community planning groups). This strategy, however, may be vulnerable to errors when data are recoded for reporting to CDC and may not address the problem of differences in how populations and interventions are defined within and across jurisdictions.

Although it can initially be challenging for a jurisdiction to adopt new definitions for populations and interventions, this approach can lead to long-term improvements in the accuracy and consistency of data collection and reporting and can improve the clarity of communications among contractors within and across jurisdictions.

While the combination of these two strategies, using both Guidance definitions and local terms, still requires the adoption of new definitions, it enables consistent and accurate reporting to CDC, facilitates clear communication among contractors within and across jurisdictions, and retains population and intervention terms relevant within the jurisdiction (e.g., "HIV-positive" and "home parties") that can be used for local data analysis and reporting purposes.

It is important to note that these three strategies are not mutually exclusive. Health departments may clarify the relationship between some local terms and the Guidance definitions and, for these terms, expect contractors to use the Guidance definitions for reporting purposes. In the same jurisdiction, other local terms that do not fit within the Guidance definitions may be retained and used by contractors as distinct reporting categories. The use of these strategies may also change over time as jurisdictions' reporting systems evolve to ensure greater uniformity and quality of data.

## Reporting Non-HIV Risk Behavior Populations

Although the Guidance defines populations by their HIV risk behaviors (except for "Mother with/at risk for HIV" and "General Population"), many jurisdictions previously defined populations in a way that does not specify HIV risk behaviors. These populations include, but are not limited to: youth, women, crack users, African Americans, homeless persons, incarcerated persons, and people living with HIV. The situational, behavioral, and demographic

characteristics used to define these populations provide important contextual information that should be considered when designing an intervention. For example, HIV positive MSM may have very different prevention needs than HIV positive IDUs. Likewise, an intervention targeting heterosexual crack users may be designed differently from one reaching heterosexuals who do not use crack. These examples clarify why the Guidance does not preclude the use of these characteristics to describe populations as long as an HIV risk behavior is also specified. Again, jurisdictions are welcome to use non-HIV risk behavior characteristics to define their populations; only the Guidance terms are required for reporting to CDC.

Jurisdictions with population definitions that do not specify an HIV risk behavior should consider which HIV risk behavior is exhibited by the population. In some cases, more than one HIV risk behavior may be present. The population "youth" may be comprised of two sub-populations, one engaging in heterosexual risk behavior, the other in MSM risk behavior. In this case, two distinct populations, based on risk behavior, may be considered when developing interventions and when collecting and reporting Guidance data.

> *"I appreciated that CDC forced us into the population definitions the way it did. Many of our contractors asked us why are you forcing us to think about how the population got HIV. There are lots of things you can say about people that are true but for a moment let's think about why they are at risk for HIV. It is a good discipline." Health Department Staff Member*

When the specific HIV risk behaviors are not known, health departments should avoid the temptation to report the population as General Population. Rather, needs assessment may be required to learn more about the population's prevention needs as a prelude to defining the population and designing effective interventions. General Population, according to the Guidance, should be reserved only for those interventions that do not target a specific risk for HIV (e.g., a city-wide media campaign to raise awareness of HIV/AIDS).

# Chapter 4: Intervention Plans

This chapter:

- Reviews intervention plan reporting requirements;
- Describes methods for collecting and managing intervention plan data; and
- Presents strategies for reporting data on clients to be served by the intervention, evidence or theory basis for an intervention, and justification of the intervention for the target population and setting.

## Intervention Plan Reporting Requirements

An intervention plan describes the goals, expectations, and implementation procedures for an intervention. For the purposes of the Guidance, an intervention is distinct from a program.

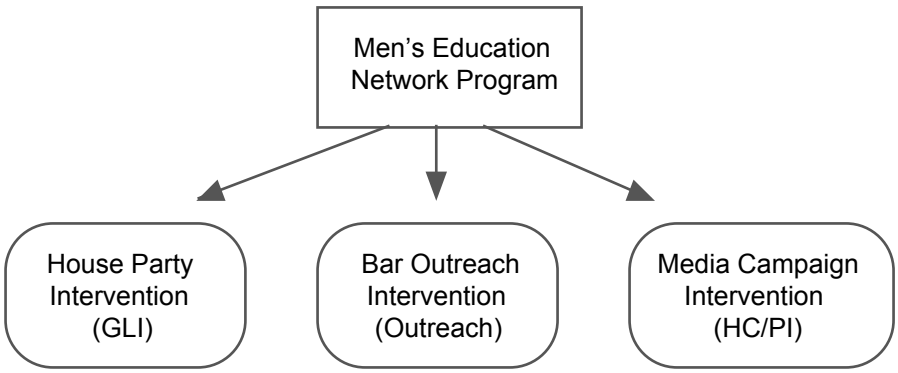
**An intervention** is a specific activity (or set of related activities) intended to bring about HIV risk reduction in a particular target population using a common strategy for delivering the prevention messages. An intervention has distinct process and outcome objectives and a protocol outlining the steps for implementation.

Example: An ILI may consist of four related sessions, but they are all provided in a clinic, through one-on-one interaction, focusing on heterosexual risk behaviors among substance users.

**A program** is a distinction often used by an agency to describe an organized effort to design and implement one or more interventions to achieve a set of predetermined goals.

Example: The Men's Education Network is a program that implements house parties as a GLI, a media campaign, and outreach conducted in bars to reduce MSM's unsafe sexual practices. The following diagram illustrates this program and its component interventions.

**A Program and its Component Interventions**



Intervention plans describe the services contractors are funded to deliver and should reflect final agreements between the health department and contractors after contract negotiations are complete. For the purposes of the Guidance, intervention plans require a core set of data elements to be reported by the health department to CDC in the aggregate by type of intervention and risk population, including:

- Type of agency;
- Number of clients to be reached, categorized by race/ethnicity and gender [2] (except HC/PI);
- Evidence or theory basis for the intervention;
- Justification of the intervention for application to the target population and setting; and
- Sufficiency of the service plan for implementing the intervention.

For a comprehensive description of intervention plan reporting requirements see the Guidance, volume 1, chapter 3. Additional information about designing and evaluating intervention plans is provided in the Guidance, volume 2, chapter 3.

## Collecting and Managing Intervention Plan Data

Health departments usually gather some or all of the required intervention plan data from proposals, workplans, and contract amendments from the contractors they fund. Unfortunately, some data required for intervention plan reporting may not be included in these documents or are presented in a manner that requires some interpretation to meet Guidance reporting requirements.

To facilitate collection of intervention plan data, some health departments have modified their requests for proposals (e.g., requests for applications, invitations to negotiate) to elicit information needed for intervention plan reporting to CDC. For example, health departments may ask their contractors to use the Guidance population and intervention definitions in their proposals, to describe the evidence or theory basis for the intervention, and provide justification of the intervention for application to the target population and setting. Reporting of intervention plan data can be simplified by developing worksheets for contractors to complete as part of their proposals. Examples of intervention plan worksheets from Colorado, Virginia, and Wisconsin are included in the Appendix, p. 80-82.

Intervention plan data reported by contractors to the health department are aggregated and then reported to CDC. Health departments may tabulate this data manually or use data management software to enter and aggregate this information. If intervention plan data are already part of an existing management information system within the health department, these data may be combined with additional intervention plan data gathered from proposals or worksheets and aggregated for reporting to CDC.

[2] Reporting data on age is encouraged but not required.

Regardless of the methods used to collect and manage intervention plan data, health departments are frequently challenged by requirements to report three types of data:

- Clients to be served by the intervention,
- Evidence or theory basis for the intervention, and
- Justification of the intervention for the target population and setting.

## Estimating Clients to be Served by the Intervention

Health departments are required to report to CDC the aggregate number and demographic characteristics of clients to be served by intervention type and population. At a minimum, client demographics should include race, ethnicity, and gender. Reporting age is encouraged but not required. Ideally, the number of unduplicated clients to be served would be reported. However, duplicate counts of the number of clients to be served are acceptable for reporting to CDC because of the difficulty of estimating unduplicated clients for some interventions (e.g., outreach).

Contractors may have difficulty with intervention plan reporting because of differences in how the number of clients to be served is estimated. Also, estimates may be compromised when a jurisdiction lacks a common understanding of how to define "served." Some contractors may count everyone who will receive a pamphlet at a community health fair; others may count only clients with whom they will have a face-to-face interaction.

Contractors may also tend to inflate estimates because they associate large numbers with success. Some may also believe that their funding organizations have this same view, highlighting concerns that funding will decrease if they do not propose to serve a large number of clients. Similarly, contractors may be inclined to propose interventions that reach a large number of clients quickly (e.g., one-time presentations) rather than those that reach fewer clients with greater depth and effectiveness (e.g., GLI).

> *"People think that proposing to reach large numbers of clients may translate into more funding. They have a dilemma in that they want to inflate the numbers but they think that if they don't reach those numbers then they'll have to lie or get caught." Health Department Staff Member*

The need to estimate clients to be served precedes the Guidance in most jurisdictions; however, the Guidance does place greater emphasis on this aspect of intervention planning and process monitoring. Three strategies are suggested for improving estimates of clients to be served in intervention plans:

- Define "served,"
- Accept smaller numbers, and
- Use past performance.

### Define "Served"

Health departments and their contractors can collaborate to define how to count clients served. This may involve establishing standards for the duration of contact with a client for them to be counted as served and defining other aspects of service delivery related to how clients are counted (e.g., clients reached through health fairs are not counted as GLI clients). See the Appendix, p. 83, for an example of how Wisconsin distinguishes between a client "contact" and an "interaction" for different intervention types.

> *"It's not that they fudge the numbers. They count things that shouldn't be counted in that intervention. I've had folks who had a two-year outreach goal of 250 people and were reporting 1,600 in the first quarter because they went to some community event with 800 people, and they did that twice. In their mind they believe that success equals large numbers." Health Department Staff Member*

Some health departments may choose to establish uniform standards for counting clients served. Others may ask contractors to first develop their own standards and then negotiate to reach agreement. Initial estimates of the number of clients to be served can then be revised. This approach can help the contractor better understand the concept of "served" and allows flexibility in using standards for counting clients depending on the intervention. The ability to compare data across interventions should be considered when determining how clients will be counted.

### Accept Smaller Numbers

Health departments are encouraged to assure contractors that funding will not be affected if reductions in the proposed number of clients to be served are the result of their plans to implement more effective interventions, with greater dosage, and in adherence with intervention standards established in the jurisdiction. This message is particularly important for contractors as a jurisdiction begins to establish uniform procedures for estimating clients.

### Use Past Performance

Process monitoring data can help in estimating the number of clients to be served in the future by the same or similar interventions. Estimates may be based on the past number of clients reached by the intervention or an analysis of cost per client served. The Guidance may help to improve process monitoring data systems and, therefore, increase the utility of these data in estimating clients to be served in intervention plans.

## Determining Evidence or Theory Basis for the Intervention

Health department staff are required to decide if intervention plans are supported by sufficient scientific evidence or theory (i.e., evidence). Multiple types of evidence can be used to support an intervention. In this section, the following four types of evidence are discussed:

- Evaluation of the same intervention,
- Evaluation of a similar intervention,
- Theory from the scientific literature, and
- Informal theory.

**Evaluation of the Same Intervention**

With this type of evidence, the proposed intervention is identical to one that has already been evaluated and shown to be effective. Congruence must exist between the proposed intervention and the evaluated intervention with regard to the population served, intervention setting, and core elements of the intervention. Though core elements may vary, for two interventions to be considered the same, contractors are encouraged to use the same content, format, and method of delivering the intervention and to deliver the same number and length of intervention sessions.

Example: A contractor proposes to conduct a GLI for African American MSM who are in an urban setting. The intervention was previously conducted and evaluated in a different city, but with the same population. Core elements of the intervention will be replicated including using the same curriculum and materials, focusing on the same content, conducting the same number of group sessions, and utilizing peer educators who have been trained to deliver the intervention.

The financial resources available may challenge the feasibility of replicating exactly a previously evaluated intervention (e.g., the same level of funding is not available with a jurisdiction). If this occurs, "evaluation of a similar intervention" may be the best choice.

**Evaluation of a Similar Intervention**

With this type of evidence, the proposed intervention is similar, though not identical, to an intervention that has already been evaluated. Although modifying a previously evaluated intervention may compromise its effectiveness, it may be necessary if available resources cannot support full implementation of the evaluated intervention or if the intervention needs to be adapted to be culturally appropriate for a different population and setting.

Generally, "evaluation of a similar intervention" means that there are differences between the proposed intervention and the previously evaluated intervention in one or more of the following areas: population served; intervention setting, content, and format; method of delivering the intervention; and the number and length of interventions session. If differences are too significant between the proposed and the previously evaluated intervention, the prior evaluation may no longer provide sufficient evidence to support using the proposed intervention.

Example: A contractor proposes to conduct an ILI for rural heterosexual Latinas. A similar intervention has been evaluated with heterosexual African American women in a rural setting. The intervention plan explains how the risk assessment protocol and educational materials used in the evaluated intervention have been adapted to be culturally and linguistically appropriate for Latinas. The number and length of

intervention sessions and the risk reduction skills addressed in each session remain the same.

**Theory from the Scientific Literature**

With this type of evidence, the proposed intervention is based on formal behavioral science theory, social science theory, or some other theory that is published in the scientific literature. The theory is divided into component parts (e.g., skills, self-efficacy) and corresponding intervention elements are then developed (e.g., intervention activities to develop condom use skills and increase self-efficacy to use condoms). When using this approach, the intervention plan cannot simply mention a theory. It must explain how the theory is integrated into the content, format, and delivery of the intervention.

Example: A contractor proposes to conduct a prevention case management intervention based on the Stages of Change theory. The intervention plan summarizes the theory, explains how it will be used to assess client readiness for behavior change, and describes how counseling strategies will be targeted to the client's stage. The plan includes an example of a risk assessment tool based on the Stages of Change theory.

> *"We've had a few problems with whether the intervention was science-based or not, because people would talk about one theory in their application, but maybe not really use it. So we came up with a list of the different behavior theories, a definition of each, and did training with them about the theories in general. And now we're asking them to check the theory they are using." Health Department Staff Representative*

A brief summary of behavioral science theories is included in the Appendix, p. 84. Another resource that describes behavioral science theories and their application to health programs is *Theory at a Glance, A Guide for Health Promotion Practice*, National Institutes of Health (NIH), September 1997 (NIH publication number 97-3896).

**Informal Theory**

With this type of evidence, the proposed intervention is based on a theory that is not described in conventional theoretical language and is not published in the scientific literature. The distinction between an informal and formal theory is subtle. Informal theory usually describes a contractor's "practice wisdom" (i.e., knowledge that comes from working with or being a member of a population) and is explained in lay terms. For example, the concept of "self-efficacy" from the behavioral science literature on Social Learning Theory may be stated as "confidence to use condoms" by someone not familiar with the formal language of behavioral science. Health departments are encouraged to work with their contractors to ensure that informal theory provides a logical explanation of why the population is at risk and to help them describe how the theory is integrated into the content, format, and delivery of an intervention that will address that risk.

Example: A contractor describes an informal theory by stating that some people are at risk for HIV because they lack confidence in their ability to use condoms, because they don't know how to talk about condom use with their sex partners, and because there are not enough positive role models in the community promoting condom use. The intervention plan describes a peer-led, individual-level counseling intervention focusing on condom use attitudes and skills, emphasizing the role of peer counselors as positive role models to promote the use of condoms.

**Summary**

Health departments may use any of the four types of evidence to help them judge whether intervention plans are supported by sufficient evidence. Two examples are provided below to further illustrate the difference between interventions that do and do not have sufficient evidence.

Sufficient Scientific Evidence: A contractor proposes to conduct an outreach intervention with MSM in public sex environments. This intervention replicates a previously evaluated outreach intervention conducted in public sex environments with the same population in a similar city.

Insufficient Scientific Evidence: A contractor proposes to conduct an outreach intervention with MSM. The intervention has not been evaluated and it does not appear to be adapted from an intervention that has been evaluated. Although the intervention plan mentions the Health Belief Model, there is no explanation of how the theory was used to develop the intervention. No other theory, formal or informal, is mentioned in the intervention plan.

**The Compendium**

The Behavioral Intervention Research Branch in CDC's Division of HIV/AIDS Prevention has compiled a review of interventions with effectiveness determined through empirical research. This review will help guide health departments and contractors in selecting interventions. Interventions are described in the Compendium of HIV Prevention Interventions With Evidence of Effectiveness, November 1999. http://www.cdc.gov/hiv/projects/rep

## Determining Justification of the Intervention for the Target Population and Setting

Health department staff are required to decide if intervention plans provide sufficient justification of the intervention for the target population and setting (i.e., justification). Sufficient justification is provided when the plan clearly explains how the intervention will lead to the specified outcomes in the specific population and in the contractor's specific setting. Justification is different from evidence. Evidence supports the rationale for the proposed intervention; justification provides greater detail about how and why the intervention will result in the stated outcomes with the specified target population and in the particular setting in which the intervention is conducted (e.g., clinic, bars, prison). Health departments are encouraged to request from contractors logic models (see below) or other descriptions of program theory that

the health department can use to assess justification for the proposed intervention. Following is an example of an intervention with and without sufficient justification.

Intervention with justification: A contractor proposes an ILI with young African American MSM to increase condom use. A needs assessment conducted for this population found that many men were hesitant to self-identify as MSM, lacked condom use skills, and did not perceive themselves to be at risk for HIV despite their high-risk sexual practices. The proposed intervention is based on a GLI conducted previously with white MSM that focused on perceived risk and condom use skills. The intervention plan explains that an ILI is justified for young African American MSM because it minimizes public disclosure of risk behavior (as compared to a GLI) and is a more culturally appropriate adaptation of the intervention for this population. Also, the intervention will be delivered at an agency that is not primarily associated with HIV prevention, providing a culturally appropriate setting for delivering prevention services. The intervention plan states that the proposed intervention will increase condom use skills and improve perceptions of HIV risk among young African American MSM, leading to an increase in condom use.

Intervention without justification: A contractor proposes an ILI with heterosexual Native American women in a rural setting that is based on a similar intervention with heterosexual Asian American women in an urban setting. The intervention plan does not explain how the intervention will be adapted to be culturally appropriate for this population and setting. Intervention outcomes are not stated nor is there any explanation of the relationship between intervention activities and the population's risk for HIV.

## Using Logic Models

A logic model describes the main elements of an intervention and how they work together to prevent HIV in a specific population. This model is often displayed in a flow chart, map, or table to show the steps leading to intervention outcomes. Elements that are connected within a logical model vary, but generally include inputs; activities; outputs; immediate and intermediate outcomes, and long-term impacts. A problem statement may be included to provide context for the logic model. Definitions and examples of each logic model component are presented below.

| **Definitions and Examples of Logic Model Components** | | |
|---|---|---|
| **Component** | **Definition** | **Example** |
| Problem Statement | Factors that put a population at risk, such as knowledge, attitudes, beliefs, behaviors, skills and environmental conditions. | MSM youth do not perceive themselves to be at risk for HIV, lack condom use skills, and have low self efficacy for condom use. |
| Inputs | Resources used in an intervention, such as money, staff, curricula, and materials. | • $50,000 grant<br>• Two 1/4 FTE prevention educators<br>• The Safe Skills Curriculum<br>• 300 Condoms |

| Component | Definition | Example |
|---|---|---|
| Activities | Services the intervention provides to accomplish its objectives, such as outreach, materials distribution, counseling sessions, workshops, and trainings. | • Conduct 3, two-hour small group sessions with MSM youth at the Youth Center<br>• Distribute condoms |
| Outputs | Direct products or deliverables of the intervention, such as intervention sessions completed, people reached, and materials distributed. | • 4 interventions conducted<br>• 40 MSM youth completed all three sessions<br>• 500 condoms distributed |
| Immediate Outcomes | Immediate results of the intervention, such as changes in knowledge, attitudes, beliefs, and skills. | • Perception of HIV risk increased<br>• Condom use skills increased<br>• Condom use self efficacy increased |
| Intermediate Outcomes | Intervention results that occur some time after the intervention is completed, such as changes in behaviors and environmental conditions. | • Condom use increased |
| Impact | Long-term results of one or more interventions over time, such as changes in HIV infection, morbidity and mortality. | • HIV rates decreased |

Logic models do take time to develop and often require the contractor to anticipate the flow of complex, dynamic processes. However, logic models are a good tool for summarizing information for justification and can also help:

- Make explicit the intended outcomes of the intervention,
- Help planners recognize when intended outcomes are unrealistic,
- Show the internal logical consistency of the intervention,
- Help identify gaps in the plan,
- Reveal assumptions about how the intervention leads to outcomes,
- Help contractors be more deliberate about what they are doing,
- Reveal when resources are not sufficient to achieve intervention outcomes,
- Help monitor progress by providing a clear plan for tracking changes to the intervention so that successes can be replicated and mistakes avoided,
- Promote communication about the intervention among contractors, funders, community members, and other stakeholders, and
- Focus evaluation of the intervention by revealing appropriate evaluation questions and relevant data needs.

See the Appendix, p. 85, for materials from Maryland that can be used to train health department staff and contractors on logic models. To receive the US-Mexico Boarder Health Association training curriculum, Outcomes *Based Evaluation Using the Logic Model, July 2000*, call the Association at 915-833-6450. This curriculum focuses on substance abuse, but could be adapted for application to HIV prevention. Additional information about logic models can be found at the CDC Evaluation Working Group website at www.cdc.gov/eval/resources.htm#logicmodel.

## Collecting Data on Evidence and Justification

Contractors need to be able to describe evidence and justification in their intervention plans. Some contractors may have difficulty reporting these data because they lack knowledge of the evaluation literature, are unfamiliar with the formal language of behavioral science and evaluation, and do not have experience in using logic models and other planning frameworks for linking behavioral theory and intervention design. In light of these challenges, the following four strategies can be used, individually or in combination, to collect intervention plan data for evidence and for justification:

- Request for proposals,
- Prescribed interventions,
- Intervention standards, and
- Community planning.

### Requests for Proposals

Requests for proposals, contract amendments, and workplans may be used to elicit intervention plan data from contractors. Health departments can use this information to judge the sufficiency of evidence and justification provided for each proposed intervention. This approach encourages contractors to explicitly consider the rationale for their proposed interventions which may result in more thoughtful planning and more effective interventions.

Contractors may need technical assistance to improve their skills in describing evidence and justification. Health department technical assistance to contractors has included training them to use logic models, providing descriptions of evaluated interventions, and distributing summaries of behavioral theories. Building contractor capacity takes time and resources and should be considered a long-term strategy.

See the Appendix, p. 84, for a summary of behavioral science theories. See *Using Logic Models*, p. 25, for additional information about logic models. For information about interventions with evidence of effectiveness, see *The Compendium*, p. 24.

> *"We tried to root our RFP on the concepts of scientific basis and justification. As part of the application, we asked that every program that was to be funded needed to provide some kind of theoretical basis or a logical framework for their intervention. They couldn't just say we're going to do this, they had to say why they were proposing to do it that way. And while we didn't restrict our funding to*

*proven effective interventions because we wanted to fund some innovation, I felt that every one of our programs gave some rationale for their work. So I can say, across the board, that all our programs have some theoretical basis for their interventions." Health Department Staff Member*

**Prescribed Interventions**

Interventions may be developed and disseminated by health departments as a way to assure that contractors are planning interventions that are supported by evidence and justification. These prescribed interventions may specify the objectives, content, and format for the intervention and include curricula and other intervention materials. Prescribed interventions may be developed through collaboration between contractors, program planners, and behavioral and social scientists. Evidence and justification reporting requirements will likely be met when health departments fund contractors to implement these prescribed interventions. Contractors may be allowed to deviate from prescribed interventions if they can provide sufficient evidence and justification to support their proposed changes.

**Intervention Standards**

Standards for intervention implementation may be developed, based on science and theory, to describe intervention elements required for specific populations. Intervention standards may describe the content and format of the intervention, duration of contact with the client, method of delivering the intervention, and other aspects of the intervention considered essential for it to be effective. Evidence and justification reporting requirements will likely be met when a health department funds interventions that are implemented according to these standards. Intervention standards tend to be less specific than the prescribed interventions described above and, therefore, may not ensure sufficient data for justification. Supplemental information may be requested from contractors to ensure that intervention plan reporting requirements are fully met. See the Appendix, p. 86, for an example of intervention standards from Colorado.

**Community Planning**

HIV prevention community planning groups should use information about behavioral science theory and evaluation to prioritize interventions. For those prioritized interventions that are being funded by the health department, the minimum requirements for evidence will be met and health departments may report those intervention plans to CDC as having sufficient evidence. To help ensure specificity in reporting requirements for justification, intervention plans submitted by contractors should include descriptions of how the proposed intervention will result in the specified outcomes in the specific population and in the contractor's specific setting. The health department can then decide if the intervention plan did or did not provide sufficient justification.

Example: Community planning might prioritize an ILI for IDUs based on research literature and behavioral science theory. For the purpose of reporting to CDC, sufficient evidence exists for intervention plans proposing to target IDUs with an ILI. For justification, however, contractors would need to specify the outcomes for the intervention and explain how they would implement the intervention to

accomplish those outcomes with this specific population in the proposed intervention setting (e.g., street, clinic).

**Summary**

The four strategies for collecting intervention plan data on evidence and justification may be combined to ensure the most effective interventions possible and to maximize the quality of the intervention plan data. A health department with intervention standards may still require a contractor to submit a proposal describing its adherence to the standards so as to ensure that the contractor fully understands the importance of these elements to deliver an effective intervention. A contractor may also be asked to articulate how the standards will be applied to a particular population and setting. Similarly, a contractor may be asked to describe evidence and justification in the proposals even if the proposed intervention was prioritized by the community planning group based on evaluation research and behavioral science theory.

# Chapter 5: Process Monitoring

This chapter:

- Reviews process monitoring reporting requirements;
- Distinguishes process monitoring and process evaluation;
- Presents strategies for data collection including developing data collection tools, collecting client-level data, documenting the risk population served by the intervention, and tracking the number of intervention sessions received by clients; and
- Describes three systems for process monitoring data collection and reporting.

## Process Monitoring Reporting Requirements

Process Monitoring is the routine documentation of data describing the characteristics of the population served, the services provided, and the resources used to deliver those services. Health departments are required to report annually to CDC aggregate process monitoring data on their CDC-funded interventions. The core set of data to be reported for all interventions includes:

- Type of agency;
- Number of clients served, categorized by race/ethnicity and gender [3] (except for HC/PI);
- Number of full time equivalent (FTE) staff used to provide the intervention; and
- Expenditures for the intervention.

Some data are only reported for certain interventions. These intervention-specific data are listed below. See the Evaluation Guidance volume 1, chapter 4, for a complete description of core and intervention-specific data reporting requirements for process monitoring.

| **Intervention-Specific Process Monitoring Data** | **Interventions** |
|---|---|
| Number of clients served by setting | ILI, GLI, Outreach |
| Number of clients receiving 1, 2, or 3 or more sessions | ILI, GLI, PCM |
| Number of prevention materials distributed | Outreach |
| Average number of PCM sessions per client | PCM |
| Number of partners identified, counseled, tested, and tested positive | PCM |
| Number of HC/PI interventions by type of agency | HC/PI |

[3] Reporting data on age is encouraged but not required.

### Distinguishing Process Monitoring and Process Evaluation

For this Guidance, process monitoring is distinct from process evaluation. Additional data are collected for process evaluation to answer more detailed questions about implementation of the intervention. Questions may include:

- Was the intervention implemented in a manner consistent with its design?
- Did the intervention reach the population most at risk?
- What barriers did clients experience in accessing the intervention?

Process evaluation is strongly encouraged, but not required, by the Guidance. See the Guidance, volume 2, chapter 4 for more information about process evaluation.

## Data Collection Strategies

A health department should choose a process monitoring data collection method that is best suited to their jurisdiction. This section describes strategies for process monitoring data collection in four areas:

- Developing data collection tools,
- Collecting client-level data,
- Documenting the risk population served by the intervention, and
- Tracking the number of intervention sessions received by clients.

## Developing Data Collection Tools

Contractors use various data collection tools to collect and report process monitoring data including simple tally sheets for documenting aggregate data about clients served through outreach or questionnaires for collecting detailed demographic and risk behavior data for each individual client receiving GLI, ILI, or prevention case management.

Data collection tools may be the same for all contractors in a jurisdiction or they may vary from one contractor to another, even when the same type of intervention is being implemented. Health departments may choose either way, but it is important to consider the advantages and limitations of each approach.

See the Appendix, p. 87-90, for examples of a data collection tools from Wisconsin, Virginia, Maryland, and New Jersey. Suggestions for developing data collection tools and sample questions can be found in the Guidance, volume 2, chapter 6.

### Contractors Use the Same Data Collection Tools

Health departments and their funded contractors can collaborate to standardize process monitoring data collection tools. Tools can be designed to collect data needed to meet Guidance

reporting requirements, as well as to gather other information of interest in the jurisdiction (e.g., client zip code, sexually transmitted disease history). Data collection tools that were in place prior to release of the Guidance may be modified to meet reporting requirements or new data collection tools may need to be developed.

Using the same data collection tools facilitates collecting uniform data throughout the jurisdiction and enables comparisons across interventions and populations. Development of these tools provides an opportunity for collaboration between the health department and contractors to define local data needs and helps cultivate "buy-in" to evaluation.

Some contractors may have invested resources in developing their own data collection prior to the Guidance. These contractors may not want to adopt new data collection tools and requiring them to do so can erode their support for conducting evaluation. Health departments should carefully consider the balance between retaining elements of existing data collection tools and establishing new standardized tools for use throughout the jurisdiction.

> *"Part of the problem with developing a common data collection system was that we had two real distinct groups of contractors. We had people who needed tons of help and any system was going to be a challenge for them because they didn't have anything. And we had people that already had something in place and were really resentful that we were replacing their system. We sort of made a decision in the beginning that if we're going to have a system, it's going be a system everybody uses. Otherwise we can't pool the data and make planning decisions."*
> *Health Department Staff Member*

**Contractors Use Different Data Collection Tools**

Health departments may permit variation in how process monitoring data are collected, with each contractor developing and using its own data collection tools. Contractors may continue to use data collection tools that preceded the Guidance, or they may modify their tools or develop new ones to better meet Guidance reporting requirements. Regardless of the data collection tools used, health departments need to ensure that contractors collect the data required for reporting.

Allowing contractors to use different data collection tools helps avoid the risk of upsetting those who are using data collection tools developed prior to the Guidance. However, variation in data collection tools will likely yield variation in data quality, limiting comparisons across interventions and populations within the jurisdiction. In addition, contractors that do not currently have data collection tools, or lack tools that collect data required by the Guidance, may not have the capacity to develop these tools on their own. Health departments can provide technical assistance to help contractors develop their own tools or they may develop optional data collection tools for those contractors that need them.

## Collecting Client-level Data

Client-level data collection involves gathering data about each individual client and maintaining that information in a database. Client data can then be retrieved, sorted, grouped, and analyzed across different variables of interest. In contrast, aggregate data collection combines information about all clients served by an intervention and does not retain client-specific data in a database. Client-level data can be pooled to yield aggregate data; however, information collected in aggregate form cannot be converted to client-level data.

Health departments can decide if they want to collect client-level data and for which interventions. Client-level data collection is usually limited to GLI, ILI, and prevention case management because these interventions usually provide sufficient interaction with clients to collect this information. Client-level data is rarely, if ever, collected during outreach or HC/PI interventions.

Client-level data collection typically involves assigning a unique identifier or code to each client. Linking a client's code and the client's data permits tracking of the individual client over time, as well as the aggregation, analysis, and reporting of data from multiple clients. The client code may be included on questionnaires and other forms for collecting data on client demographics, risk behaviors, intervention services received, and other variables of interest. Client codes can be generated by the client or the contractor.

Client-Generated Codes: The client creates a code by responding to a series of prompts, such as client initials, birth date, and mother's first name. With client-generated codes, the code is designed so that clients know all the information needed to complete the code themselves, though contractors may assist if necessary.

Contractor-Generated Codes: The contractor assigns a code to a client based on a series of prompts, such as provider initials and a number for each consecutive client seen by the provider. With contractor-generated codes, the contractor must create the code for the client because the client may not have all the information needed (e.g., provider initials). A master list is often maintained linking client codes and client names to ensure that clients are assigned the same code during subsequent contacts.

### Client Code Examples

Methods used by different jurisdictions to create client codes are described below. Following these, a method suggested by the Health Resources Service Administration (HRSA) is described. The examples provided are for a white male, non-Hispanic client named John Doe, born on March 16, 1963. John is the fifteenth client served by a provider named Mary Smith.

| Examples of How to Create Client Codes | | | |
|---|---|---|---|
| **Jurisdiction** | **Who Creates Code** | **How Code is Created** | **Example** |
| Virginia | Client | 1st and 3rd letter of first name, 1st and 3rd letter of last name | JHDE |
| Maryland | Client | birth month, birth day, complete birth year, gender, race, ethnicity | 03161963MWN |
| New Jersey | Client | 1st and 3rd letter of first name, 1st and 3rd letter of last name, birth month, last two digits of birth year | JHDE0363 |
| Wisconsin | Contractor | Provider initials, consecutive number from the first client | MS015 |

HRSA creates a client code, called a Unique Record Number (URN), using the following method: 1st and 3rd letter of first name (if blank, use the middle initial), 1st and 3rd letter of last name (if blank, use the middle initial), birth month, last two digits of birth year, and gender code (1=male, 2=female). For example, JHDE03631. After this number is created, it is encrypted, or scrambled, using a complex algorithm. The resulting nine-digit code does not resemble the original information in any way. It is virtually impossible to retrace the information in the URN or retrace any personal information about a client. Decoding a URN is not feasible; too much of the original information is removed during the encryption process to be able to work backwards to the original 11 digit information. [4]

**Client Confidentiality**

Concerns about confidentiality can hinder efforts to collect client-level data and should be considered. Client codes typically avoid using complete names, portions of social security numbers, or any other information that may reveal the client's identity. Even in the absence of information that could reveal client identity, clients may perceive the potential for breeches of confidentiality and therefore be hesitant to report risk behaviors or to utilize prevention services that collect client-level data. These concerns may be particularly salient for clients engaged in illegal or stigmatized behaviors. Contractors may also be concerned about confidentiality issues and resist collecting client-level data.

Confidentiality concerns can be addressed in different ways. One health department conducted focus groups with clients and learned that they would feel more comfortable if contractors did not see client-level data. In this jurisdiction, clients generate their own code and complete questionnaires. These questionnaires are placed in a sealed envelope, which the contractor collects without seeing the information and sends to the health department for data entry and analysis. In a different jurisdiction, clients did not want the health department to have access to

4 This information about HRSA's URN comes from the Careware Users Manual, Appendix C.

client-level data. In this case, the contractor collects and aggregates client-level data. Only aggregate reports are submitted to the health department. Both approaches show a positive response to the particular concerns in each jurisdiction.

**Benefits of Client-Level Data**

Collecting client-level data facilitates reporting several process monitoring data elements required by the Guidance, including client race, ethnicity, gender, and age; risk population served; number of clients served; and number of intervention sessions received for ILI, GLI, and PCM. (See p. 38 for more information about documenting the number of intervention session received.) In the absence of client-level data, health departments may not be able to report this information accurately. These data also may be useful for local evaluation and planning purposes beyond the Guidance requirements.

The advantages of client-level data are contrasted with aggregate data in the following example. A three session GLI targeting heterosexuals serves six clients. Jurisdiction A collects aggregate data, and Jurisdiction B collects client-level data. Both jurisdictions collect data on risk, race, gender, and the number of intervention sessions received.

Aggregate Data Collection: Jurisdiction A collected and reported the following aggregate data upon completing the three sessions GLI.

| Number of clients attending intervention sessions by risk, race and gender | | | Number of clients attending the first, second and third intervention session | | |
|---|---|---|---|---|---|
| Risk | Race | Gender | First | Second | Third |
| 5 Hetero<br>1 MSM | 3 White<br>3 Black | 3 Male<br>3 Female | 6 | 3 | 3 |

In this example, aggregate data do not permit reporting of client race by gender because these demographic data were collected and reported independently. There is no way to identify the race of the one MSM client served by the intervention nor is it possible to know how many intervention sessions were received by each client (i.e., only the number of clients attending each session is known). Without this information it is difficult for Jurisdiction A to report all required Guidance data.

Client-Level Data Collection: Jurisdiction B collected and reported the following client-level data upon completing the three session GLI.

| Client | Risk | Race | Gender | Number of sessions completed |
|---|---|---|---|---|
| Client 1: | Hetero | White | Female | 2 |
| Client 2: | MSM | Black | Male | 3 |
| Client 3: | Hetero | Black | Male | 3 |
| Client 4: | Hetero | Black | Female | 3 |
| Client 5: | Hetero | White | Male | 2 |
| Client 6: | Hetero | White | Female | 2 |

In contrast to aggregate data, client-level data reveals greater demographic detail about clients served. These data show that the one MSM client was Black and that none of the White clients received more than two intervention sessions. These data also reveal that three clients received two intervention sessions and three clients received three intervention sessions. This more detailed information makes it easier for Jurisdiction B to report Guidance data.

Client-level data can reduce the need for contractors to collect data each time they see a repeat client. For example, if contractors collect demographic and other data during the first contact with a client, they can then use the client's code to access the information for reporting subsequent visits.

**Challenges of Client-Level Data**

Client codes must protect client confidentiality. Ideally, these codes are a unique, unduplicated identifier for each client. Using last names or portions of social security numbers (e.g., last four digits) in the code can decrease the possibility of code duplication. However, these elements are usually avoided to mitigate client concerns about confidentiality. Efforts to maintain confidentiality can make it difficult to avoid duplication, reducing the quality of client-level data.

Codes may also be unstable over time for the same client. For example, a client may have multiple names or nicknames that undermine the consistency of a code that uses initials or letters from their name. It may not be possible, therefore, to create client codes that eliminate the possibility of duplication and that are completely stable over time. Duplicate and unstable codes can compromise data quality. Health departments should be mindful of these problems and try to minimize their occurrence.

## Reporting Risk Population Served

Contractors report data to the health department about which risk populations were served by their interventions (e.g., MSM, IDU). For some intervention types (e.g., PCM), conducting a risk assessment can provide data to be used to report on the risk population served. With other interventions (e.g., outreach), a risk assessment cannot always be conducted and other methods must be used to report on the population served. Three strategies can be used to document the risk of clients served by an intervention:

- Client self-report,
- Contractor perception, and
- Intervention intention.

Although some approaches produce better quality data than others, health departments may choose which method they will use. One strategy may be used by all contractors throughout a jurisdiction or strategies may vary across interventions and contractors within a jurisdiction.

### Client Self-Report

With this strategy, contractors gather self-reported data about risk from the clients they serve. Risk-assessment data should always be collected with PCM interventions. Risk assessment may also be conducted for clients in GLI and ILI if there is sufficient contact with the client to perform an assessment. Data may be collected as part of a comprehensive risk assessment appropriate for PCM, may involve a shortened risk assessment tool, or may be a simple questionnaire in which clients indicate the risk population to which they belong. Questionnaires may be completed by clients themselves or the contractor can elicit the information and complete the questionnaire for them. Client codes may be included on the questionnaire to facilitate collection of client-level data. (See p. 33 for more information about collecting client-level data.)

Clients may not always be truthful about reporting their risk behaviors, and the sensitive nature of risk behavior questions may alienate some clients. Despite these concerns, self-reported data are likely to yield the most reliable information about the risk populations served. Contractors may find that clients are more truthful about reporting their risk behaviors as trust and rapport develops after several contacts. Under these circumstances, self-reported risk data may give the appearance that a client's risk is initially increasing during the course of the intervention. For this reason, contractors may consider waiting until the second or third contact with the client to collect risk data; however, if a client does not return for services, then an opportunity to collect data during the first contact will have been missed. Health departments are encouraged to carefully consider the circumstances under which they would allow a contractor to delay collecting data on self-reported risk.

### Contractor Perception

When it is not possible to collect self-reported data, the risk population served may be based on a contractor's perception of a client's risk. This approach is often used during outreach interventions because it is difficult to conduct a risk assessment during the brief contacts with clients typical in this intervention. Accurate reporting depends on contractor knowledge of the prevalence of risk behaviors in an outreach location (e.g., gay bar, shooting gallery) or knowledge of the particular risk population with whom they are working. Although reporting risk based on contractor perception minimizes the possibility of alienating a client by asking explicit questions about risk, it is likely to be less accurate than client self-reported data.

### Intervention Intention

When risk assessment is not possible, and the contractor is unsure of client risk, the risk population may be reported based on the intention of the intervention. For example, if an intervention is designed to serve MSM, then everyone reached by the intervention is assumed to be MSM and is reported as such. This approach may misclassify the risk of some clients and yield unreliable data. Although reporting risk in this manner is in compliance with the minimum expectations of the Guidance, this method should only be used when there is no alternative.

## Documenting the Number of Sessions Received

Health departments are required to report the number of clients receiving only 1, only 2, or 3 or more intervention sessions for GLI, ILI and PCM. The number of sessions received by a client is one measure of the intensity of the intervention. Documenting the number of sessions is fairly easy for ILI and PCM. The one-on-one nature of the interaction between contractor and client simplifies record keeping to collect this data.

GLI can present some unique challenges to documenting the number of sessions because attendance may be fluid during the course of the intervention. For example, in a four session group-level intervention, some clients may drop out after the first session, others may attend just the first and third, and others will participate in all four. With several participants in a group and multiple sessions over time, it can be difficult to track the number of sessions received by clients.

Health departments can use the method they prefer to collect data documenting the number of intervention sessions received. The following four strategies are discussed below:

- Client-level data,
- Sign-in sheets,
- Contractor recall, and
- Client recall.

One strategy may be used by all contractors in a jurisdiction or health departments may allow variation in how these data are collected. Using one strategy throughout the jurisdiction will likely yield uniform data, facilitating comparison across contractors and interventions. Variation in methods allows flexibility to accommodate the needs of different interventions, but may yield data of varying quality. Health departments are encouraged to consider the advantages and disadvantages of each strategy and to collect these data in a manner most appropriate for their jurisdiction.

### Client-Level Data

Collecting data on each individual client is one way to document the number of sessions received. (See p. 33 for more information about collecting client-level data.) These data can be tabulated to determine the distribution of sessions received by all clients. In a variation of this method, some contractors use client codes without collecting the risk behavior data that usually accompanies client-level data collection. Clients maintain their confidentiality by using their code to sign-in for each intervention session attended and these data are used to track the number of sessions received. See the Appendix, p. 91, for an example of a sign-in sheet from Maryland.

Example: A four session GLI is conducted for six clients. Clients sign-in at each session using a client code based on the 1st and 3rd letter of their first name, 1st and 3rd letter of their last name, birth month, and last two digits of birth year. (See p. 33 for information about creating client codes.) The following table shows data collected after four sessions.

| Client Code Data for a Four-Session GLI | | | |
|---|---|---|---|
| **Session 1** | **Session 2** | **Session 3** | **Session 4** |
| CMLA0573 | CMLA0573 | CMLA0573 | CMLA0573 |
| DVNP0363 | | | |
| DDRA1164 | DDRA1164 | | DDRA1164 |
| SKCH0970 | | SKCH0970 | |
| ARIA1071 | ARIA1071 | ARIA1071 | ARIA1071 |
| | CRMK1265 | | |

This data can be used to determine the number of intervention sessions received, e.g., 2 clients attended 1 session, 1 client attended 2 sessions, and 3 clients attended 3 or more sessions

> *"One of the biggest problems was collecting information about the number of sessions. It was really difficult to track that without having a unique identifier for each client. We were asking questions like how many clients completed a one session ILI, how many completed two sessions, and that relied on the contractor having the ability to track that information. What we found was they just couldn't do it without a client code." Health Department Staff Member*

**Sign-In Sheets**

Clients can use their name to sign an attendance sheet for each intervention session received. Attendance is tracked over time to determine the number of sessions received by each client and aggregated to determine the distribution for all clients. Although this approach is simple to use, clients may not feel comfortable revealing their names or may use different names each time they sign in (e.g., nicknames), compromising the quality of the data collected. Any identifying information used on the sign-in sheet must be kept confidential.

**Contractor Recall**

This approach relies on the contractors' ability to recognize clients and remember who did and did not attend sessions. Alternatively, contractors may rely on the staff at the agency or institution hosting the intervention to remember how many sessions clients attended. Similar to the other methods, this information is used to determine the number of sessions received by each client and aggregated to determine the distribution for all clients. Although this approach is unobtrusive, poor recall can compromise data quality.

**Client Recall**

Contractors can ask clients to self-report how many intervention sessions they have attended. For example, at the end of a three session GLI, clients can be asked to report how many of the three sessions they attended. Although the simplicity of this approach may be appealing, data cannot be collected from clients who do not attend the last session. Data quality may also be

compromised by poor client recall and the possibility that some clients will be biased to over-report the number of sessions they attended.

## Data Reporting and Management Systems Overview

Data reporting and management systems are used by health departments to collect, aggregate, and analyze process monitoring data. These systems establish procedures for monitoring data quality, transmitting data from contractors to the health department, creating a database, and producing CDC- and jurisdiction-specific reports. Three data reporting and management systems are described below:

- Health Department-Based Systems,
- Contractor-Based Systems, and
- Web-Based Systems.

The key features of each system are summarized on p. 42. No one system is best for all jurisdictions. Health departments are encouraged to consider the strengths and limitations of each system as they develop a data reporting and management system for their jurisdiction.

### Health Department-Based System

Health departments use data management software such as Microsoft Access or Excel to enter and manage process monitoring data reported to them by their contractors. Contractors typically collect process monitoring data on paper forms and submit these records to the health department for data entry.

Jurisdictions using this approach have established different schedules for data submission. Data may be sent to the health department after each intervention event or it may be accumulated and submitted in batches monthly, quarterly, or bi-annually. In some cases, the contractor collects and aggregates data over time and submits a summary report to the health department. This approach, however, requires that the contractor has a method for tabulating data.

Data submitted to the health department are reviewed by health department staff, checked for missing or inconsistent data, and either scanned or entered manually into a database. Missing or inconsistent data may be identified by visually reviewing the data for apparent errors (e.g., no risk population is reported) or by using a computer-based data edit program. This process allows the health department to identify and correct reporting errors and to assist contractors in improving the quality of future data submissions.

The health department uses these data to produce reports for CDC in compliance with Guidance requirements and may also generate reports for use by health department staff, contractors, and other stakeholders. Data management software may be preprogrammed to conduct data analysis and produce reports that meet CDC and jurisdiction-specific information needs.

### Contractor-Based System

Contractors use data management software housed at their agency to enter and manage their own process monitoring data. This approach requires that all contractors have access to a computer and data management software and that they are all collecting and reporting the variables specified in the Guidance, regardless of the software they are using. Some health departments have made standard software available to all contractors. Others have allowed them to use the software of their choice (e.g., Microsoft Excel, Access). Contractors typically collect process monitoring data on paper forms and later enter the information into a database. In some cases, data are entered directly into the computer while the intervention is being conducted, eliminating the need for a paper form.

Data entry is performed by the staff member delivering the intervention or by other staff within the agency. Data entry screens can be designed to minimize data entry errors by incorporating skip patterns and menus with set options for data entry. After data entry, data can be submitted to the health department by e-mail or on diskette, usually on a monthly, quarterly, or bi-annual schedule. These data are reviewed, checked for errors, and then combined to create a master database at the health department. By checking for missing or inconsistent data, the health department can correct mistakes and assist contractors in improving the quality of future data submissions. However, since the original data collection forms are usually not submitted to the health department, it may be difficult to detect data errors that occurred during the data collection or entry process.

The master database is used to produce reports for CDC in compliance with Guidance requirements. Additional reports may also be generated for use by health department staff, contractors, and other stakeholders. Data management software may be preprogrammed to conduct data analysis and produce these reports.

### Web-Based System

Contractors may access a web-based system at their agency to enter process monitoring data and to transmit the data to the health department. This approach requires that all contractors have access to a computer with an Internet connection linked to a web page for data entry. Similar to the contractor-based system described above, contractors collect process monitoring data on paper forms and later enter the information into the Internet system. Alternatively, they may enter the data directly into the computer while the intervention is being conducted, eliminating the need for a paper form.

Data entry screens can be designed to minimize data entry errors by incorporating skip patterns and menus with set options for data entry. Data entry and submission to the health department generally occurs immediately after the intervention, or on a monthly or quarterly schedule. Data are automatically aggregated by the system to create a master database at the health department. This database is used to produce reports for CDC in compliance with Guidance requirements. Additional reports may also be generated for use by health department staff, contractors, and other stakeholders. The system may be preprogrammed to conduct data analysis and produce these reports.

**Combining Systems**

These three systems may be used alone or in combination depending on the needs of the jurisdiction. For example, a health department may use a contractor-based system with most of their contractors and use a health department-based system for those contractors that do not have the capacity to enter and manage their own data. This combination may be used as an interim strategy while data entry and management capacity of contractors is further developed. Likewise, these strategies may be sequenced over time as part of a developmental approach for the jurisdiction. For example, a health department-based system might be used for all contractors as a way to closely monitor and improve data quality as a first step in a long-range plan to establish a web-based system.

> *"The grantees have a choice about doing data entry. Some want to do it and some don't want to do it because it is too complicated for them. They just want to fill out the forms, and we'll get somebody to do the data entry for them here at the health department. Those who have the ability and enough staff to actually enter data will just do the data entry on site." Health Department Staff Member*

| **Key Features of Data Reporting and Management Systems** | | | |
|---|---|---|---|
| **Questions** | **Health-Department Based System** | **Contractor-Based System** | **Web-Based System** |
| What technology is needed? | Health department access to a computer and data management software | Contractor access to a computer and data management software | Contractor access to a computer with an Internet connection linked to a web page for data entry |
| How are data entered? | Data entered manually or scanned by health department staff | Data entered by contractor staff | Data entered by contractor staff |
| How is data quality ensured? | Health department staff review data collection forms for completeness and accuracy | Data entry screens are designed to limit data entry errors | Data entry screens are designed to limit data entry errors |
| How are data transmitted? | Paper forms are mailed to the health department | Electronic file is sent to the health department by e-mail, or a diskette is hand delivered or mailed | Electronic file is sent to health department via the Internet |
| Who accesses data to produce reports? | Health department staff | Health department staff and contractors | Health department staff and contractors |

## Choosing a Data Reporting and Management System

Health departments should consider the strengths and limitations of each approach when choosing a data reporting and management system. There are important differences across systems in terms of the technology required, responsibility for data entry, mechanisms to monitor data quality, implications of the frequency of data submissions, and the ability to access data for analysis. These five issues are described below.

### Technology

Technology needs should be considered when choosing a data reporting and management system. Health department-based systems do not require the contractor have computer access or literacy; however, health department staff will need skills to establish and manage the database. Contractor-based and Web-based systems both require the contractor to have access to a computer; the latter is also dependent on an Internet connection linked to a web page for data entry. Contractors must also have staff that are literate in the data management software or Internet system used. Maintaining staff computer capacity can be challenging given the frequent turnover experienced by many contractors. Web-based systems have an added advantage over contractor-based systems in that the former avoids the challenge of identifying and deploying software compatible with different computers and operating systems.

### Data Entry

Consideration should be given to contractor and health department capacity to conduct data entry. In health department-based systems, health department staff conduct data entry; with contractor-based and web-based systems, data entry is performed by the contractor. While the burden on the contractor is reduced when the health department assumes responsibility for data entry, this task can require significant time and resources from the health department and may limit opportunities to develop contractor data entry capacity. However, some health departments perform data entry as an interim strategy while simultaneously developing contractor capacity to perform data entry in the future.

### Data Quality

Systems vary in how they monitor data quality. Contractor-based and web-based systems can be designed to facilitate correct data entry and reporting. Data entry screens can be constructed with menus, internal checks, contractor-specific access codes, and other features that prevent entry of spurious data. Data entry screens may even be tailored to the specific intervention the contractor is funded to deliver, ensuring that the intervention type and risk population are correctly reported. These strategies require standardization of the data entry screen. This is easily accomplished with web-based systems or when the health department provides the same data management software to all contractors.

> *"With the web-based system, there'd be a log-in screen were contractors would put in information, like their agency name, and up would pop a list of the interventions that matched whatever they were funded to do. This would take them*

*directly to the page where they need to enter the data, so there wouldn't be any of that thought process anymore about how or where to report the information." Health Department Staff Member*

Health department-based systems manage data quality by reviewing paper data collection forms submitted by their contractors. The same features for data entry screens described above can be used with health department data entry to improve data quality. Health department-based systems have the added advantage of allowing health department staff to review and identify errors on the original paper forms completed by contractors. Although the other two systems typically do not involve reviewing these forms, health departments may ask their contractor to submit the paper forms so they can be compared with the electronic data submitted.

**Reporting Schedule**

The frequency of data submission from contractors to the health department is not dependent on a particular system, and the implications of reporting frequency vary depending on which system is used. For contractor-based and web-based systems, the longer the delay between collecting intervention data and reporting it to the health department, the greater the need for contractors to store the data until it is reported. Contractors may vary, however, in their capacity to keep their data collections forms organized and secure. With quarterly data submissions, contractors may be inclined to save their process monitoring data for three months and then enter it all at once. If records were not well maintained, the quality of the data may be compromised. With health department-based systems, frequent data submissions help avoid a backlog of data waiting to be entered at the health department. Regardless of the systems used, frequent reporting enables health departments to monitor data quality, intervene quickly when there are problems, and conduct interim analysis to help monitor progress in meeting objectives.

*"We have them do the reports monthly because it is hard to respond to problems if you are finding out three months after the fact that there is a problem and also because of what we know about the reliability of recall. Unless people are filling out their forms during the intervention, which some do, some have it on clipboard, it is hard to remember and report the data accurately." Health Department Staff Member*

**Data Analysis**

Although all three systems can be designed to automatically conduct data analysis and produce reports, the ability to access the data and produce these reports varies. With health department-based systems, the database resides at the health department and contractors depend on the health department to conduct data analysis and produce reports for their use. In contrast, contractor-based systems permit contractor access to the database and allow them to generate their own reports, as needed. Web-based systems also permit contractor access to the database; access can be restricted so that contractors view data only from their own interventions.

# Chapter 6: Outcome Monitoring and Outcome Evaluation

This chapter:

- Reviews outcome monitoring and outcome evaluation reporting requirements,
- Distinguishes outcome monitoring and outcome evaluation,
- Presents criteria for selecting an intervention for outcome monitoring or outcome evaluation,
- Provides examples of outcomes appropriate for evaluation,
- Describes the basic design for outcome monitoring,
- Describes an evaluation design that avoids common concerns about outcome evaluation, and
- Explains the purpose of an Institutional Review Board.

## Outcome Monitoring and Evaluation Reporting Requirements

Health departments with at least $1 million in cooperative agreement funding from CDC are required to collect and report outcome data for either an outcome monitoring or outcome evaluation project during the cooperative agreement period. Health departments may choose whether to conduct outcome evaluation or outcome monitoring. The specific reporting requirements for these two types of evaluation are described below.

### Outcome Monitoring Reporting Requirements

Health departments that choose to conduct outcome monitoring are required, for the year 2002, to conduct this evaluation with at least 10 percent of their contractors who are implementing interventions appropriate for outcome monitoring. These data are to be reported in April 2003. For the year 2003, health departments are required to conduct outcome monitoring with 20 percent of their contractors and report their findings in April 2004. It is up to each health department and its contractors to decide which interventions to evaluate. It may be preferable to conduct outcome monitoring with a variety of interventions rather than with the same intervention across several contractors.

Reports to CDC on outcome monitoring projects should contain the following information:

- names and affiliations of evaluators conducting the outcome monitoring;
- intervention type;
- intervention goals;
- target population;
- evidence and justification for the intervention;
- copy of instruments and data collection tools;
- methods of data collection and statistical analysis;
- appropriate descriptive statistics, including client demographics;
- summary of findings; and
- how results will be used for program improvement.

## Outcome Evaluation Reporting Requirements

Health departments that choose to conduct outcome evaluation are required to evaluate at least one distinct HIV prevention intervention or set of integrated interventions. The intervention should be of sufficient design and maturity of development to warrant a rigorous evaluation. The evaluation design should be quasi-experimental, using a non-equivalent comparison group or multiple measurements before and after the intervention. When feasible, health departments may use an experimental design with random assignment of clients to treatment and control groups. Any experimental-type design (e.g., assignment of clients to treatment and control groups or comparison of outcomes between clients in standard and enhanced interventions) must undergo local Institutional Review Board (IRB) approval. No contact with "human subjects" in an experimental-type design may take place without local IRB approval. (See p. 52 for more information about IRBs.)

One outcome evaluation report is due to CDC in September 2003 with health departments' applications for funding. The report should contain the following information:

- names and affiliations of evaluators conducting the outcome evaluation;
- intervention type;
- intervention goals;
- target population;
- evidence and justification for the intervention;
- evaluation design and methods;
- sample sizes for treatment and comparison groups and numbers of participants lost to attrition (as appropriate);
- copy of instruments and data collection tools;
- methods of data collection and statistical analyses;
- appropriate descriptive statistics, including client demographics;
- summary of findings (e.g., attrition, overall outcomes, and any subgroup analyses of differences due to demographics, features of the intervention, or other variables); and
- how results will be used for program improvement.

### Distinguishing Outcome Monitoring and Outcome Evaluation

Outcome monitoring and outcome evaluation both involve collecting data about client outcomes before and after the intervention. Outcome evaluation, however, also collects data from people not participating in the intervention or, in some cases, collects data from clients at several points in time both before and after the intervention. This difference in how data is collected underlies an important difference in what can be learned from these two types of evaluation.

> **Outcome monitoring** tells you if the expected outcomes occurred.
>
> **Outcome evaluation** tells you if the intervention caused the expected outcomes.

The difference between outcome monitoring and outcome evaluation is illustrated with the following example. A contractor implemented a GLI consisting of four small group sessions with heterosexual African American women who are partners of IDUs. One of the stated outcomes is to increase condom use by 25%. For outcome monitoring, a questionnaire was used to measure condom use before and after the intervention. When the intervention was complete, program staff found that condom use increased by 35%.

The increase in condom use may be the direct result of the intervention or there may be other explanations for why condom use increased. Perhaps some women knew that prevention staff wanted them to use condoms, and they were not truthful on the final questionnaire, reporting that they used condoms more often than they really did. Maybe outreach workers from another intervention were recently working in this neighborhood distributing condoms, resulting in increased condom use. It is possible that some of the increase in condom use is the result of the intervention and some is due to these or other factors.

In this scenario, outcome monitoring would show that the stated outcome of increasing condom use by 25% was exceeded. But outcome monitoring cannot rule out other factors that might be responsible for this change. If outcome evaluation where conducted, then the same questionnaire would also be used to measure condom use among women not participating in the intervention.

By comparing changes in condom use among women participating and not participating in the intervention, outcome evaluation can better assess how much of the change among participants was caused by the intervention and how much was the result of other factors. For a more comprehensive discussion of the distinction between outcome monitoring and outcome evaluation, see the Guidance, volume 2, chapters 6 and 7.

## Selecting an Intervention for Outcome Monitoring and Evaluation

Regardless of whether health departments choose to conduct outcome monitoring or outcome evaluation, there are important criteria to consider when selecting an intervention to evaluate. Outcome evaluation and, to a lesser extent, outcome monitoring are more complex and resource intensive than other evaluation activities required by the Guidance. To ensure the effective use of evaluation resources, health departments are encouraged to carefully select interventions for evaluation that will produce valid findings useful to the health department, contractors, and CDC.

The criteria listed below can be used to screen interventions being considered for outcome monitoring and outcome evaluation and to identify one or more good candidates. Health departments are free to consider additional criteria relevant to their jurisdiction. If no currently funded intervention meets these criteria, health departments can use the criteria to guide efforts to strengthen an intervention as a prelude to evaluating.

**SMART outcomes**: Intervention outcomes should be Specific, Measurable, Appropriate, Realistic and Time-based. If the expected outcomes of the intervention are not clearly stated, outcome monitoring cannot assess if the outcomes occurred and outcome evaluation can not

determine if the intervention caused these outcomes. Interventions with unclear outcomes should not be selected for evaluation. (For more information about creating outcome objectives, see the Guidance, volume 2, chapter 3.)

**Defined intervention plan**: The intervention should have a strong basis in formal or informal theory and clearly explain how intervention activities will lead to the outcomes (i.e., sufficient evidence and justification). Without a clear intervention plan it will be difficult to know why the expected intervention outcomes did or did not occur.

**Fidelity to the intervention plan**: The intervention should be implemented consistent with the intervention plan. For a variety of reasons, an intervention is not always implemented as intended. Process monitoring and process evaluation data can be used to assess consistency with the intervention plan and to help identify interventions appropriate for evaluation. Variation from the plan will make it difficult to know what "version" of the intervention caused the outcomes. (For a more complete discussion of the relationship between implementation and outcomes, see the Guidance, volume 2, chapters 6 and 7.)

**Stability over time**: The intervention should not be changed during the evaluation. Changes to the intervention will confound understanding of which aspects of the intervention achieved, or caused, the stated outcomes. Health departments should consider the organizational strength of the contractor implementing the intervention, reliability of funding for the intervention, compatibility of the intervention with local laws and ordinances, and other factors that may impact the stability of the intervention over time.

**Sufficient reach**: Interventions should be considered for outcome monitoring or outcome evaluation if they reach a sufficiently large number of clients (i.e., sample size) to apply statistical tests necessary for data analysis. The number of clients needed depends on several factors, including the evaluation design, the intended outcomes, and the intensity of the intervention. (For more information about sample size, see the Guidance, volume 2, chapter 7.)

**Sufficient dosage**: Clients should have sufficient exposure to the intervention to result in the intended outcomes. Interventions with limited client contact are less likely to result in measurable outcomes as compared with interventions that provide more in-depth intervention with clients.

**Obtainable data**: Interventions should be considered for outcome monitoring or outcome evaluation if the data needed to measure outcomes are reasonable and accessible. Health departments should avoid attempting outcome monitoring and outcome evaluation on interventions that may have difficulty following up clients to collect post intervention data.

**Contractor capacity**: The contractor implementing the intervention should have the capacity and motivation to partner with the health department to conduct outcome monitoring or outcome evaluation. These evaluation activities may place an additional burden on the contractor in terms of resources, staff training, intervention monitoring, and data collection. The contractor should be well informed about roles and responsibilities in this endeavor and be a willing participant.

**Utility of findings**: An intervention should be selected for which outcome monitoring or outcome evaluation will produce findings useful to the health department and its contractors and clients. In choosing an intervention to evaluate, health departments should seek to address gaps in understanding about interventions within their jurisdiction.

## Developing Outcomes Appropriate for Evaluation

An important objective of HIV prevention is to reduce HIV incidence by changing risky behaviors. Measures of behavior change are preferred for outcome monitoring and outcome evaluation. Predictors of behavior change, such as changes in knowledge, attitudes, beliefs, skills, behavioral intentions, or other domains, are acceptable for evaluation purposes and are preferable if post-intervention data are collected before there is an opportunity for behavior change to occur (e.g., immediately after the intervention). When predictors of behavior change are used, the evaluation plan should describe the formal or informal theory that explains how changes in these domains will lead to behavior change.

Outcomes should be stated in clear and measurable terms and be appropriate for the intervention to enable a good evaluation. For example, "reduce high-risk sexual behavior" may be the stated outcome for a given intervention. The meaning of "high-risk" and "sexual behavior" must be defined by asking questions such as: Does it include oral sex? and /or Does it include intercourse with a long-term partner? Maybe the only behavior addressed in the intervention is vaginal intercourse with an injection drug-using partner. How much these behaviors will be reduced must also be considered. Does the intervention intend to entirely eliminate sexual risk behaviors for all clients receiving the intervention or just for some? Similarly, one must consider if the outcome is appropriate for the intervention. Perhaps the intervention focuses primarily on needle use and does not have sufficient emphasis on sexual risk behaviors to result in the desired behavior change. Clarification of the intended outcomes of an intervention is an important step in preparing to evaluate. (For more information about creating outcome objectives, see the Guidance, volume 2, chapter 3).

Examples are provided below to illustrate the different types of outcomes that may be used for outcome monitoring or outcome evaluation and the level of specificity appropriate for their description. Health departments may identify other outcomes for the interventions they choose to evaluate. These examples are **not** meant to be a comprehensive list nor are the percentages or time frames meant to suggest CDC's expectations for changes in these particular indicators. Health departments should collaborate with their contractors to develop outcome objectives appropriate for each intervention and targeted population. (For more information about different types of outcome objectives, see the Guidance, volume 2, chapter 6).

| Examples of Outcomes for Outcome Monitoring and Evaluation | |
|---|---|
| Behaviors | • Consistent use of condoms during vaginal sex with non-main partners will increase 30% three months post intervention.<br>• Frequency of sharing needles to inject drugs will decrease 20% three months post intervention. |
| Knowledge | • Knowledge about routes of HIV transmission will increase 35% at the end of the intervention.<br>• Knowledge of where to get free condoms will increase 80% three months post intervention. |
| Attitudes and Beliefs | • Intentions to use condoms consistently during anal sex with non-main partners will increase 40% at the end of the intervention.<br>• Self-efficacy to avoid sex while high on drugs will increase 25% three months post intervention. |
| Skills | • Correct condom use skills will increase 75% at the end of the intervention.<br>• Skills to correctly clean needles with bleach and water will increase 30% three months post intervention. |

## Designing Outcome Monitoring

Outcome monitoring requires, at a minimum, the collection of outcome data at least once before and once after the intervention (commonly known as the one-group pretest and posttest design). If feasible, health departments are encouraged to collect a second set of follow-up data after the intervention. This second set of data helps determine the extent to which changes among clients are sustained over time.

> *"We're going to look at how many of our contractors are interested in doing outcome monitoring and start to move them in that direction, making it a real collaborative process. They've already been saying that they'd like to know if they're making a difference and changing behaviors. So we are taking their lead on this, and they'll get lots of technical assistance from us to develop an evaluation plan and the necessary tools." Health Department Staff Member*

Health departments are also encouraged to collect data over time on multiple clients participating in the intervention. Combining outcome data from multiple clients participating in the intervention yields a larger sample size, enabling statistical analyses that produce more robust findings and can, therefore, be more useful to program improvement.

Interventions appropriate for outcome monitoring include ILI, GLI, PCM, and client-centered counseling in the context of HIV counseling, testing, and referral. It may not be feasible to carry out outcome monitoring for street outreach and HC/PI because of the difficulty of collecting follow-up data after the intervention is complete. (For more information about designing outcome monitoring studies, see the Guidance, volume 2, chapter 6.)

## Designing Outcome Evaluation

The Guidance states that health departments may use a quasi-experimental design with a non-equivalent comparison group or multiple measurements before and after the intervention. An experimental design with random assignment of clients to treatment and control groups may also be used, when feasible. This type of design requires local Institutional Review Board (IRB) approval. (For a more complete discussion of evaluation design, see the Guidance, volume 2, chapter 7.)

Health departments and contractors may find it undesirable to use a comparison or control group in their evaluation. There may not be sufficient numbers of clients to deliver the intervention to some and have others serve as a comparison or control group. Even if there are enough clients, ethical concerns may prevent withholding the intervention from some clients.

> *"We cannot get a control group here. We're not in a place where the epidemic is horrible, so anybody that we could identify, there's a space for them in an intervention. So sort of prolonging them getting into the intervention, that's just not morally and ethically the right thing that we want to be doing." Health Department Staff Member*

These concerns can be minimized by comparing a basic and enhanced intervention for outcome evaluation. This evaluation design is discussed below.

### Comparing a Basic and Enhanced Intervention

Comparing a basic and an enhanced version of the same intervention is an experimental design and requires local IRB approval. It does not, however, withhold an intervention from clients and, therefore, avoids some of the concerns associated with the typical use of comparison and control groups. In this design, two versions of the same intervention are delivered to two comparable groups of clients and each group serves as a comparison for the other.

Example: A basic intervention involves a two-hour group education session with heterosexual male youth. This session uses didactic methods such as lecture and video to address basic prevention and transmission issues and a demonstration (but not practice) of correct condom use. The enhanced version of the intervention involves four, two-hour group education sessions with heterosexual male youth. This intervention uses participatory methods such as role play, skills practice, problem solving, and facilitated dialogue. The intervention addresses prevention and transmission issues and includes several exercises in which participants practice condom use skills.

In this scenario, the participants in one intervention can serve as a comparison group for the other. The relative effectiveness of both interventions can be compared by assessing the extent to which they each achieved a common set of outcomes (e.g., changes in knowledge, attitudes, beliefs, behaviors, and skills). However, because the evaluation lacks a comparison or control group that does not receive an intervention, it is not possible to entirely control for other factors

that may affect intervention outcomes (e.g., clients receiving another intervention at the same time they participate in the intervention being evaluated).

This evaluation design addresses the need to identify effective alternatives to ineffective interventions and avoids ethical concerns about denying client access to the intervention. However, if the jurisdiction already has credible evidence that the enhanced intervention is more effective that the basic intervention, then the enhanced intervention should not be denied to any client and a different basic and enhanced intervention set should be evaluated. Many jurisdictions usually do fund some type of basic intervention, and this evaluation design can be used to help determine if the basic intervention can be improved. Comparing basic and enhanced interventions can be a pragmatic approach to conducting outcome evaluation that meets Guidance requirements, avoids some of the concerns related to other designs, and is compatible with the array of intervention types being conducted in many jurisdictions.

### Institutional Review Boards

An IRB is a group established to protect the welfare of human subjects recruited to participate in biomedical or behavioral research. IRBs are responsible for reviewing and supervising proposed research to make sure they are in compliance with minimum standards for protection of human subjects.

Health departments must receive IRB approval when conducting outcome evaluation using an experimental-type design, such as assignment of clients to treatment and control groups or comparison of outcomes between clients in basic and enhanced interventions. Contact with human subjects in an experimental design is only permitted with local IRB approval. IRB approval pertains to the health department that funds the intervention undergoing outcome evaluation as well as to the contractor(s) implementing the intervention, known as the "performance site" for IRB purposes. Depending on the jurisdiction, local IRB review and approval may be required for evaluation designs other than experimental-type designs. Health departments should check with their IRB before starting outcome evaluations.

Health departments conducting outcome evaluation using an experimental-type design will need to submit to CDC a copy of their application to their local IRB, including the evaluation protocol and a copy of the IRB's response. Because CDC is not a co-investigator in the outcome evaluation, health departments do not need to apply for approval from the CDC's IRB.

IRBs review research protocols to ensure that they comply with standards for protection of human subjects as described in the Federal Policy (also know as the Common Rule). Health departments and contractors conducting outcome evaluation with an experimental-type design must enter into a binding commitment to the Common Rule before research begins. The document containing this binding commitment is called an "assurance." There are several types of assurances including: Multiple Project Assurance, Federal-wide Assurance, Inter-Institutional Amendment, Cooperative Amendment, Single Project Assurance, and Cooperative Project Assurance. Each type of assurance is appropriate for different circumstances.

IRBs are registered with the Office for Human Research Protections (OHRP), US Department of Health and Human Services. An OHRP website maintains extensive information on IRBs and the different types of assurances (http://ohrp.osophs.dhhs.gov). The following website can be used to identify local IRBs: http://ohrp.osophs.dhhs.gov/humansubjects/assurance/iorg-a-f.htm.

# Chapter 7: Evaluation Plans

This chapter:

- Reviews the reporting requirements for evaluation plans and
- Describes information in excess of the requirements that may be included in evaluation plans.

## Evaluation Plan Reporting Requirements

CDC requires that each health department create an evaluation plan prior to beginning the evaluation activities described in the Guidance. Health departments submitted their initial evaluation plans to CDC in September 2000, along with their funding applications for fiscal year 2001. Evaluation plans should be revised annually and submitted to CDC.

The evaluation plan outlines the activities the health department will undertake to implement the Guidance and meet reporting requirements. The goal is for the health department to create a plan that will guide the collection and reporting of evaluation data that meet each of the Guidance reporting requirements, improve HIV prevention efforts, and inform stakeholders of the progress made in HIV prevention.

At a minimum, the evaluation plan should answer the three questions listed below. Sub-topics are included for each question to further clarify the types of information to be addressed. These questions represent a simplification of the six steps for creating an evaluation plan listed in the Guidance, volume 1, chapter 8.

1. How will each of the Guidance reporting requirements be met?
    - What is the health department's plan to meet Guidance requirements including timelines, roles, and responsibilities for staff and contractors?

2. How will evaluation data be collected, managed, and used?
    - What systems are currently in place to collect and manage required data?
    - How and when will systems to collect and manage required data be improved (if necessary)?
    - How are evaluation data currently being used, and by whom?
    - How will evaluation data be used in the future?

3. What are the evaluation technical assistance (TA) needs for the jurisdiction?
    - What are the unmet evaluation TA needs of health department staff, contractors, and other relevant stakeholders?
    - How and when will unmet TA needs be addressed?

Health departments may choose how to organize this information in their evaluation plan. The most common approach used by health departments for plans submitted in September 2000 was to organize the plan according to the chapters of the Guidance. Using this approach, health

departments can clearly describe how required data will be collected, managed, and used for each reporting requirement, as well as describe any unmet evaluation TA needs related to meeting those requirements. Technical assistance needs that are not specific to a Guidance chapter, or that relate to several aspects of the Guidance, can be described in a separate section. Another common approach was to organize the plan according to the goals and objectives for implementing Guidance activities. Within this structure, the plan describes action steps for meeting Guidance requirements; collecting, managing, and using evaluation data; and identifying and addressing TA needs.

CDC requires health departments to update their plans annually. Jurisdictions may choose to use one of the formats described above, or any other structure they prefer, for revising their plan and clarifying how they will proceed with Guidance activities. (For more information on creating an evaluation plan, see the Guidance, volumes 1 and 2, chapters 8 and 9.)

## Reporting Additional information

CDC undertook a national review of evaluation plans submitted in September 2000, to better understand progress in Guidance implementation. A data abstraction form was developed to guide analysis of what information was and was not described in the plans. To ensure a comprehensive review, this form enabled abstraction of information that exceeded expectations for evaluation plans as described in the Guidance. When the results of this review were shared with health department staff, several suggested that the data abstraction form could serve as a useful guideline for health departments interested in further developing their evaluation plans.

Health departments may include information in their evaluation plan that exceeds the minimum reporting requirements. However, this is not expected or required. For those that choose to go beyond the minimum requirements, the following list of topics, gleaned from the data abstraction form, may provide ideas about other information to include in the plan. Health departments may choose to address one or more of these issues, or may include any other information they deem relevant.

**Additional Information That May be Included in Evaluation Plans**

- Health department and non-health department resources and capacity for evaluation including overall funding, supplemental funding, non-CDC funding, evaluation staff, and consultants.
- Systems for using the Guidance risk population and intervention definitions for reporting and strategies for reconciling differences between the Guidance definitions and jurisdiction-specific definitions.
- Barriers to collecting data on any particular variables (e.g., age data, scientific basis)
- Methods for designing and delivering interventions that can be evaluated.
- Evaluation activities in excess of Guidance requirements, such as process evaluation and quality assurance.
- Approaches to collaborating with stakeholders to develop the evaluation plan.
- Strategies to get evaluation buy-in from stakeholders.

# Chapter 8: Beyond the Guidance

This chapter:

- Describes why health departments and contractors may not "buy-in" to the Guidance,
- Suggests strategies for developing support for evaluation, and
- Lists ways Guidance data can be used to improve prevention efforts in the jurisdiction.

## Developing Evaluation Buy-In

Implementation of Guidance activities is facilitated when health department staff and contractors see the benefit of collecting, managing, and using evaluation data. Health departments who have achieved some successes in Guidance implementation report that developing evaluation "buy-in," both internally and with their contractors, was an essential step in their process. For a variety of reasons, however, contractors and health department staff may resist the Guidance and its reporting requirements.

### Challenges to Getting Buy-in

Contractors and health department staff may be concerned about the time and resources necessary to collect and report Guidance data. In general, they consider service delivery to be their first priority, and the Guidance may not be valued unless they feel the data can be used to improve their prevention programs. Some may consider data collection activities to be potentially disruptive to service delivery and damaging to client trust and rapport. In addition to these concerns, some may fear that evaluation results will suggest that interventions are not successful and will negatively affect funding. Although many jurisdictions had data collection and reporting systems in place prior to the Guidance, the increased emphasis on intervention plans and process monitoring may amplify any existing concerns that interventions will be deemed ineffective.

> *"There's a big fear that evaluation means we're going to find out something bad about their intervention and the next year their money's going to be gone. A lot of it just has to be education that that's not what this process is about, that it is about making sure we're delivering the most appropriate services." Health Department Staff Member*

### Strategies for Getting Buy-in

Contractors and health department staff are motivated to implement evaluation systems that yield useful data. Health departments are encouraged to consider how data will be used to improve prevention efforts within their jurisdiction as they plan for implementation of Guidance activities. The Guidance represents only a minimal data set and, therefore, health departments

may want to consider additional data needs within the jurisdiction that can be addressed by evaluation systems established to meet Guidance requirements.

Some health departments collect data in excess of Guidance requirements to address local evaluation needs, including:

- Client state of residence, county, and zip code;
- Client STD history and HIV status;
- Client knowledge, attitudes, and beliefs related to HIV risk;
- Behavioral and situational co-factors for HIV risk;
- Topics and skills addressed in the intervention; and
- Contractor demographics and training relevant to the intervention.

Health department are encouraged to present the Guidance to contractors as an opportunity to gather data to improve programs locally, and not just as a CDC requirement. Using this approach, contractors are more likely to consider how they can use the data themselves and, perhaps gather additional data to address local evaluation needs.

> *"It's worth the time to put in place a substantive data collection process locally that responds to immediate and longer term needs. Really spend the time before you get into the technical aspects of data collection to ask the questions you really want answered, then apply the technical analysis to what is possible. A lot of us shoot ourselves in the foot by constructing data systems to meet minimal requirements, which end up being a lot of work and a lot of time and a lot of burden on the contractor where a little more thinking would have gotten you a lot more useful data." Health Department Staff Member*

Regardless of whether data collection is limited to or exceeds the Guidance requirements, health departments should consider collaborating with their contractors to design procedures for data collection and reporting. Engaging contractors in the process of developing data collection instruments, deciding how evaluation data will be used, and planning other aspects of the evaluation system can help address concerns about evaluation's impact on service delivery, foster ownership of the evaluation process, and develop buy-in for evaluation activities. Consistent with the community development approach used in some HIV prevention interventions, involving the contractor "community" in creating and deploying the jurisdiction's evaluation system can enhance evaluation behavior.

> *"The contractors who are generating the data are one of your end users and so their needs have to get met. Having them generate the broad questions as well as working on the implementation steps really saves you not only a lot of political headache but actually a lot of practical headache, because they can tell you what won't work, and they always come up with stuff that you would never think of from your desk in the main office. They really have their finger on the pulse of what their staff are capable of." Health Department Staff Member*

Although Guidance requirements may increase the data collection burden on contractors, evaluation systems can be designed to reduce reporting burden. Health departments are encouraged to eliminate redundancies between quantitative data required by the Guidance and the qualitative narrative reports some health departments require of their contractors. Narrative reports to the health department may provide important information about interventions and should be maintained at the discretion of the jurisdiction. However, health departments should continue to identify and eliminate areas of overlap in their reporting procedures. Contractors have and will welcome these improvements.

The magnitude of contractor evaluation responsibilities can also be reduced when the health department manages contractor data. When contractors are allowed to send client-level data to the health department for data entry the contractor no longer has to tabulate and report aggregate data, eliminating a time-consuming task that many contractors are happy to avoid. (See p. 33 for more information about client-level data.) Some health departments have reduced the burden on contractors by allowing them to use a portion of their prevention funds to support evaluation tasks or by allocating additional resources for this purpose.

## Using Evaluation Data

An important goal of the Guidance is to provide information to improve prevention services. Although the Guidance is still early in implementation and health departments have not yet had an opportunity to fully explore all the ways the data may be used, several suggestions for using the data have emerged. These ideas are listed below. Health departments are encouraged to explore these and other opportunities to use evaluation Guidance data to strengthen their prevention efforts.

> *"The contractors are excited about actually receiving feedback reports about what they did. Contractors will submit process and outcome data and we'll develop standardized reports so they can monitor their own progress. We'll provide feedback at the agency-level and the health department will probably look at this across agencies within intervention types." Health Department Staff Member*

**Planning Interventions:** Intervention plan and process monitoring data can help increase contractor awareness of the range of possible interventions; highlight important distinctions between different intervention types; and improve the quality of interventions through consideration of evidence, justification, and sufficiency of the service plan. These data can also prompt contractors to be more specific about the risk behaviors they want to change and the rationale for how they would conduct an intervention to achieve these changes. Process monitoring data in particular can inform subsequent intervention plans, especially estimates of the number, demographics, and risk behaviors of clients to be served. Using past performance to inform future plans provides a basis for contractors and health department staff to identify realistic expectations for intervention performance.

*"One thing we discovered was how many agencies are doing AIDS 101, which may have been considered by some to be a group-level intervention. But it's not, and the Guidance was useful in helping people to understand what an intervention* is and is not." *Health Department Staff Member*

**Monitoring Interventions:** Intervention plan and process monitoring data can be compared to assess the congruence between the intentions of an intervention and its actual performance. This assessment can occur during implementation to identify opportunities to strengthen the intervention during the funding cycle and at the end of a contract to inform decisions about future resource allocation and ways to improve interventions for the next funding cycle.

*"One of our contractors who worked with gay youth had done some group-level interventions and had planned a three- or four-session group. By tracking that they found that the implementation was really very shaky because the youth would go to one session but not commit to attending three or four. And it was through looking at the process measures that they saw this." Health Department Staff Member*

**Identifying Gaps:** Process monitoring data can be used by community planning groups to document the extent to which interventions are reaching high-priority populations with priority interventions. This information is an important component of a resource inventory — a requirement for community planning groups — and can help identify current gaps between prevention priorities and actual performance. Identification of gaps in prevention services can guide future efforts to better reach priority populations with priority interventions.

*"We've talked about being able to do some mapping, something real visual where people could actually see where the GLIs are located and map that on top of where our HIV rates were high and be able to see holes." Health Department Staff Member*

**Focusing Evaluation:** Process monitoring data help select interventions that are appropriate for more in-depth study using outcome monitoring and outcome evaluation and, in this way, ensure the effective use of evaluation resources. These data can be used to identify interventions that demonstrate fidelity to the intended program model, reach a sufficient number of clients, and meet other criteria necessary for an intervention to be evaluated. (See p. 47 for more information about selecting interventions for evaluation.)

**Securing Funds:** Evaluation help document intervention success in reaching risk populations. This information can be used to support funding applications submitted to health department and non-health department sources to continue the intervention. Documentation of intervention success is increasingly expected from contractors by a variety of funders, and these data can support efforts to expand the resources available to support prevention services.

**Improving Communication:** Intervention plan and process monitoring terms used in the Guidance establish a common language for planning and evaluation in general, and for describing populations and interventions specifically. This helps to facilitate communication

among contractors, between contractors and the health department, and between the health department and CDC. Improved communication contributes overall to the use of evaluation data and the improvement of prevention services.

# Chapter 9: Guidance FAQs

Listed below are CDC's answers to frequently asked questions (FAQs) about the Guidance. These FAQs were previously distributed at CDC's 2001 First Annual HIV Prevention Program Evaluation Meeting in Atlanta, June 19-20, 2001. They are reproduced here and some additional questions and answers have been added. Questions were identified from three sources: 1) issues that emerged during the initial Guidance trainings for health departments conducted in Atlanta, January - March 2000, 2) issues identified during interviews with health departments and other stakeholders conducted during the development of this manual, and 3) Guidance-related technical assistance requests to CDC. Answers to these questions were developed and approved by CDC with input from NASTAD, health department representatives, and other stakeholders.

## Time Lines and Dues Dates

**May jurisdictions phase-in process monitoring?**

Data are due in April 2001. As is the case for all issues and concerns about the Evaluation Guidance, issues and concerns about the submission of process monitoring data should be discussed with project officers. CDC is aware of the challenges health departments may face in securing process monitoring data, especially for the first time, and will work with jurisdictions to help resolve any problems.

**How should we coordinate the timing of process monitoring data and the progress reports?**

Progress reports on activities that took place the previous year are due each April. Data on monitoring the implementation of prevention programs are due in April since the data cover activities that occurred the previous year. The first set of data for monitoring program implementation is due in April 2001 for the period, January - December 2000.

**Since individual jurisdictions may have unique funding cycles, how should intervention plan data be reported?**

Intervention plan data (chapter 3 of the Evaluation Guidance) should be submitted to CDC in September with health departments' applications for cooperative agreement funding. Intervention plan data cover the period January - December 2001. CDC is aware that some jurisdictions may not have their intervention plan data available in September because contracts with grantees for the year beginning January 1 may not be in place then. These situations should be discussed with project officers and a reasonable deadline for submitting the data should be agreed upon.

**For outcome evaluation, what is actually due in September 2003?**

Grantees receiving at least $1 million in cooperative agreement funding who choose to conduct outcome evaluation are to report the results of an outcome evaluation of at least one intervention in September 2003. The types of information to report are described in Volume 1 of the Evaluation Guidance. The Supplemental Handbook, Volume 2 of the Evaluation Guidance, contains more information on how to conduct outcome evaluation. Technical assistance requests should be channeled through project officers.

## Membership Grid Data

**Where do you count people on the membership grids who work with a population but aren't actually members of that population (e.g., people who counsel IDUs but aren't IDUs themselves)?**

The "membership grids" ask for CPG (community planning group) representation by primary and secondary agency and primary and secondary expertise (among other types of representation). If persons work with at-risk populations but are not actually members of the population, they could be counted as an agency representative and/or a representative with expertise in behavioral or social science or interventions.

## Evaluating Linkages

**For Chapter 5 of the Evaluation Guidance on evaluating linkages between the prevention plan, funding application, and resource allocation, are jurisdictions to report service units or number of interventions?**

Chapter 5 discusses the evaluation of two types of linkages: 1) linkages between the comprehensive HIV prevention plan and the CDC funding application and 2) linkages between the comprehensive HIV prevention plan and resource allocation.

To evaluate linkages between the comprehensive HIV prevention plan and resource allocation, jurisdictions should compare interventions funded in the previous year with interventions recommended in the prevention plan for that year. It is suggested that jurisdictions submit the worksheet found in the appendix to Chapter 5. That worksheet asks for interventions (recommended in the plan and funded) by name of intervention, not by service units or numbers of interventions.

To evaluate linkages between the comprehensive HIV prevention plan and the CDC funding application, jurisdictions are asked to report which recommended interventions in the plan are not included in the application. There is a worksheet in the appendix to Chapter 5 that can assist jurisdictions in listing the interventions recommended in the plan and funding application.

Jurisdictions should note that the interventions in the comprehensive HIV prevention plan that are compared to the CDC funding application and to resource allocation could be intervention types, such as individual-level counseling and street outreach, or interventions at specific locations such as individual-level counseling carried out at the St. James public housing development, or outreach conducted at the corner of 14th Street and Mulberry Place. Also, the target populations in the comprehensive prevention plan may not be the same as the target populations in the Evaluation Guidance. The Evaluation Guidance uses risk population categories, including MSM; MSM/IDU; heterosexual contact; and mother with/at risk for HIV while jurisdictions may have target populations in their plans that are not based on a risk behavior, such as the homeless, youth, and incarcerated persons.

Beyond these evaluations of linkages, jurisdictions are free to perform enhanced evaluations of linkages that will provide additional data useful for community planning. For example, an expanded worksheet could be used to indicate interventions that do not have CDC funding, such as interventions funded by the state. This enhanced information will minimize the appearance of "gaps" in service.

**Can alternative means of demonstrating linkages between comprehensive plans, applications, and funded interventions be used instead of the forms in the Guidance?**

The data on linkages need to be reported to CDC; the example forms in the Guidance are provided for reporting convenience. Other ways of reporting the same data are acceptable.

The Evaluation Guidance requests minimum data on the demonstration of linkages; jurisdictions may report additional data. CDC understands that looking at interventions funded solely by CDC funding may create the "appearance" of gaps, when - in fact - the gaps are filled by interventions receiving non-CDC funds.

## Issues Related to Both Intervention Plans and Process Monitoring

**On the forms for intervention plans and process monitoring, should we count all clients if the intervention is only partially funded by CDC, or should we use a "pro-rated" number?**

For interventions where CDC cooperative agreement funding is only one funding source, health departments should "pro-rate" the number of clients who receive the intervention with CDC cooperative agreement funding. Departments should know what percentage of funding cooperative agreement funds represent for the intervention and use that percentage to figure out the "pro rated" number of clients. For example, if CDC cooperative agreement funding represents 75 percent of the funding for the intervention, then 75 percent of the clients should be considered CDC clients. The gender, race and ethnicity of these clients (and their ages, if possible) should also be identified. The distribution of gender, race and ethnicity for the 75 percent should represent the distribution for all clients receiving the intervention. For example, there are 100 clients; 50 are African American males; 25 are Latino males; and 25 are White males. The jurisdiction would report 75 clients: half (50 percent) are African American males =

38 African American males; 25 percent are Latino males = 19 Latino males; 25 percent are White males = 18 White males.

**The forms in the Evaluation Guidance on process monitoring ask for statewide definitions or guidelines for the intervention being reported on, but the forms for intervention plans do not ask for this information. What does CDC want and when should the material be submitted?**

CDC would like to receive one set of definitions or guidelines for each jurisdiction's interventions. This material should be submitted with intervention plan data since those data are due before the process monitoring data. For convenience, jurisdictions may submit one master list, rather than separate definitions or guidance for each risk population per intervention.

**The forms in the Evaluation Guidance on intervention plans and process monitoring ask about interventions provided by various types of agencies. How are minority CBOs, faith communities, and individual agencies defined?**

A minority board CBO has a board or governing body composed of greater than 50 percent of the racial/ethnic minority population to be served, and members of the racial/ethnic minority population to be served must serve in greater than 50 percent of key positions in the organization, including management, supervisory, administrative, and service provision positions.

The Evaluation Guidance refers to "Faith Community." For the Evaluation Guidance, a faith community can include faith-based CBOs as well as other faith-based entities funded to carry out HIV prevention, such as a coalition of clergy. Specifically in regard to faith-based CBOs, CDC defines them as organizations that have a faith, spiritual, or religious focus or constituency, and have access to local faith, spiritual and religious leaders and communities. Examples of faith-based CBOs include individual churches, mosques, temples, or other places of worship; a network or coalition of churches, mosques, temples, or other places of worship; or a CBO whose primary constituents are faith, spiritual, or religious community organizations or leaders.

"Individual" does not refer to an agency, but to an individual person not affiliated with a public or private agency or organization; e.g., an individual hired as a consultant.

**How do you report the type of agency when it can fit more than one category for intervention plan and process monitoring data?**

Health departments need to decide on just one code for an agency that can fit more than one code. Choose the description that BEST describes the grantee or the one code the grantee would use to describe itself.

**Should the client designation on the Evaluation Guidance forms that reads "Asian/Pacific Islander" be reworded to separate Asian and Pacific Islander?**

The race and ethnicity designations on the forms are being revised to conform to federal reporting requirements established by the Office of Management and Budget and CDC guidelines for consistency in data collection. The races will include "American Indian or Alaska Native;" "Asian;" "Black or African American;" "Native Hawaiian or other Pacific Islander;" and "White." The forms will also include "Hispanic or Latino," and "Not Hispanic or Latino." These revised forms will be available next year and should be used for the submission of intervention plan data in September 2001 (covering the period, January - December 2002) and process monitoring data in April 2002 (covering the period, January - December 2001).

**What is the definition of Hispanic?**

Hispanic or Latino is defined as "a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race."

**How should race and ethnicity be recorded when data are based on observation for outreach?**

Best estimates should be used to record and report process monitoring data.

**Why do the Evaluation Guidance forms include an "unknown" category for gender but not for race and ethnicity?**

As noted above, the forms are being revised to meet federal directives and be more consistent internally.

**Why are there different age categories on the Evaluation Guidance forms compared to the budget tables?**

The budget tables refer to age in regard to budgets for one category – "young people" 13 to 25 years of age. The Guidance forms have three categories for age: 19 or younger; 20 - 29; and 30+ years old to capture three important age distinctions: youth, young adults, and older adults. The Division of HIV/AIDS Prevention is working to reconcile any differences in the ways age data are reported. Since different branches may report and/or collect age data in different ways (for example, one group may want more fine-tuned data than three categories will allow), CDC is working to assure that data can be "collapsed" so the categories can fit one another.

**Will CDC understand that differences between intervention plan data on clients to be served and data on clients served in process monitoring may be due to difficulty documenting risk behaviors rather than interventions failing to reach clients?**

Yes. CDC requests that health departments explain these challenges in a narrative format.

## Intervention Plans

**For intervention plans, should jurisdictions estimate clients or contacts?**

Ideally, the best estimate for unduplicated clients to be served by the particular intervention should be reported. However, contacts are acceptable for outreach only. For all data collection by intervention, jurisdictions should do their best to collect unduplicated client counts.

**If community planning considers scientific evidence and justification when prioritizing interventions, and the health department then funds these interventions, does this meet requirements for scientific evidence and justification for intervention plans? Or are grantees expected to submit additional information on scientific evidence and justification?**

CDC's Guidance on HIV Prevention Community Planning, calls for CPGs to prioritize populations at high risk for HIV and to prioritize culturally and linguistically appropriate interventions for them. Criteria to be considered in prioritizing interventions include outcome effectiveness; relative costs and effectiveness; sound scientific theory when outcome effectiveness information is lacking; and values, norms, and preferences of the communities for whom services are intended. The Guidance states, "At a minimum, the community planning groups must provide a clear, concise, logical statement as to why each population and intervention given high priority was chosen."

With this in mind, intervention plans that include populations and interventions based on the priorities set in the comprehensive HIV prevention plan will meet the requirements for "evidence or theory basis for the intervention." This is the very minimum criterion for asserting the evidence or theory basis for the intervention. However, the community planning process will most likely not go into enough detail to provide evidence to justify application to the target population AND setting. In order to assert justification for the target population and setting, CDC prefers that health departments request logic models or depictions of program theory from applicants and/or grantees that show the proposed relationship between the intervention and expected outcomes for the particular target population in a particular setting.

Health departments that have Requests for Proposals (e.g., requests for applications, invitations to negotiate, etc.) that ask applicants to specifically discuss the evidence or theory basis of proposed interventions as well as justification for application to the target population and setting will meet requirements for scientific evidence and justification. In addition, if the RFPs also ask applicants to specifically discuss factors relating to the sufficiency of the service delivery plan (e.g., provider training and supervision, quality assurance and accountability mechanisms), this, too, will meet the requirements for sufficiency of the service delivery plan.

If the criteria above are met, grantees should not be expected to submit additional information.

**What are the minimum bounds of acceptability for scientific evidence and justification for intervention plans? What would be an example?**

Chapter 3 of the Evaluation Guidance contains discussion of how to assess the intervention's evidence basis and how to assess the intervention's justification to the target population and setting. There is also discussion on how to determine the sufficiency of the service plan. More extensive discussion is found in Chapter 3 of Volume 2: Supplemental Handbook. CDC's Guidance on community planning, referenced above, is another source of information on factors to consider in prioritizing interventions.

As noted above, the minimum bound of acceptability for scientific evidence is compliance with the CPG-approved priorities in the comprehensive prevention plan. However, the minimum bound of acceptability for justification is a logic model or program theory description that shows the relationship between the intervention and expected outcomes for the particular target population in a particular setting. If health department grantees were funded based on applications that provided a high quality discussion of the evidence or theory basis of interventions and justification to the target population in a particular setting, then those descriptions are acceptable.

**What should one do if the intervention changes after it has been funded? Should health departments submit revised intervention plans? What are the implications for comparing intervention plan and process monitoring data?**

The intervention plan data that health departments submit to CDC may be considered "benchmark" data for health departments and CBOs to use to set the stage for process evaluation; that is, understanding how and why process monitoring data differ from intervention plan data. If process monitoring data reveal that fewer (or even more) clients are being served than anticipated by intervention plan data or that different populations are being reached than those originally targeted, this is useful information to use to modify interventions to realistically meet client needs. This information should then be used to set more realistic plans for the next year.

If, for example, an intervention is dropped and another one added for a target population, this information should not be submitted to CDC. Health departments should not submit revised intervention plan data to CDC. Intervention plan data are to be submitted only once a year.

CDC recognizes that intervention plans change and a strict comparison of intervention plan and process monitoring data would often show major differences between the two sets of data.

**What is to be written in the "Notes/Comments Field" on intervention plan forms?**

As the Evaluation Guidance indicates, the "Notes/Comments Field" is an optional field health departments may use to provide explanation, clarification, or additional information about the data provided on the form. Health departments are not required to provide notes or comments.

## Intervention Definitions

**How do we distinguish between individual level interventions (ILIs) and counseling and testing in process monitoring?**

An ILI may or may not lead to testing, and all ILI clients seen outside of the counseling and testing site per se -- whether they go on to get tested or not -- are counted in process monitoring for ILIs. Clients who are counseled as part of pre-test counseling should not be counted as ILI clients. Counseling and test site clients are reported on the HIV counseling and testing report form.

**Is outreach for counseling and testing not considered part of outreach?**

"Outreach" is generally defined as educational interventions conducted face-to- face in places where clients congregate. For the purpose of the Evaluation Guidance, outreach solely for the purpose of getting clients into counseling and testing, should not be included under "Outreach."

In regard to "Partner Counseling and Referral Services (PCRS), for intervention plans and process monitoring, are we counting HIV+ index cases or the partners of HIV+ persons who are notified and counseled?

The first page of the forms for intervention plan and process monitoring data for PCRS ("HIV-Infected Clients to Receive PCRS with CDC Funds" and "HIV- Infected Clients Who Received PCRS with CDC Funds," respectively) refers to HIV+ index cases. Page 2 of the process monitoring form for PCRS asks for data on the sex or needle sharing partners of HIV+ index cases.

**Where do we report on CTRPN and coalition building as interventions?**

The forms in the Evaluation Guidance for reporting intervention plan data as well as process monitoring data do not cover CTRPN and coalition building. It is suggested that you provide a narrative report that describes these efforts.

**Can CDC funding be used for policy interventions?**

CDC funding, like all funding from Congress, cannot be used to lobby federal or local legislative bodies. CDC funds may not be used for propaganda purposes or for the preparation, distribution or use of such items as publications or radio or television presentations designed to support or defeat pending legislation.

However, CDC funding may be used for community-level interventions that seek to lessen risky conditions and behaviors in a community through a focus on the community as a whole. As the Evaluation Guidance points out, this is often done by attempting to alter social norms or characteristics of the environment. Such efforts are also referred to as "structural interventions" and may be funded with CDC cooperative agreement funding.

Specific questions regarding structural interventions and whether they meet funding requirements should be referred to project officers.

**What intervention would you use for a "chatroom" on the Internet; for example, a chatroom for MSM?**

HIV/AIDS health education and risk reduction information provided to persons via a chatroom should be considered under "Other Interventions" on the forms for intervention plans and process monitoring. The intervention is not necessarily an individual-level intervention, according to the intervention types in the "Evaluation Guidance," since more than one individual is reached, and it's not necessarily a group-level intervention or health communications and public information. Use the form for other interventions or provide a narrative description.

**The definition of Prevention Case Management (PCM) in the Evaluation Guidance seems more loosely defined than CDC's guidance on PCM. Which definition applies?**

CDC's guidelines on PCM are not mandates for how PCM should be implemented. For evaluation, use the definition of PCM in the Evaluation Guidance. This broader definition will include the definition found in CDC's PCM guidance. As with all the intervention categories, national data about PCM will include some data from more rigorous implementation and some from less rigorous implementation. This is also true of ILI, GLI, and outreach interventions.

**What constitutes "skills building" for GLI? Does every participant in a GLI need to demonstrate the skill or is it sufficient for one client to demonstrate the skill and the others to observe?**

A variety of skills can be "built" during GLI (and ILI). If, for example, the skill is condom use and a phallic model is used to demonstrate how to fit a condom and at least one member of the group participates in the demonstration, the entire group can be considered as having participated in the skill building exercise. Critical thinking and decision-making skills are skills that can be enhanced during GLI. If these skills are discussed and demonstrated by members of the group through various exercises or activities, the entire group can be considered as having participated in the intervention.

**What is really meant by CLI (community-level interventions) and social marketing? What is the distinction between CLI and a set of related but distinct interventions working toward a common goal (e.g., an agency implementing outreach, ILI and GLI targeting MSM in a particular community)? Should a CLI be deconstructed into its component interventions and then each intervention separated for intervention plans and process monitoring reporting?**

As the Evaluation Guidance puts it, "CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples include community

mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions."

Social marketing is the application of commercial technologies to the planning and implementation of prevention programs. Social marketing is not social advertising, social education, attitude change, or socially responsible marketing of HIV prevention messages. Examples of social marketing programs at CDC include the "America Responds to AIDS" campaign and the "5-A-Day Nutrition" campaign.

The definition above of CLI indicates that it does not focus on individuals or small groups whereas outreach, ILI, and GLI do focus on individuals and small groups. If a grantee employs a set of related but distinct interventions working toward a common goal, it is appropriate to "deconstruct" that program into its component elements and report on each intervention separately for intervention plan and process monitoring data.

**How should an intervention be categorized that counsels couples and includes skills building and/or service brokerage? What if it does not include skills building or service brokerage?**

An intervention that counsels couples and includes skill building and service brokerage should probably be categorized as GLI (the intervention could be considered PCM if it meets the criteria for PCM established by the health department or grantee or if it is carried out in accordance with CDC's guidance on PCM). In this example, "counseling" refers to HIV/AIDS prevention counseling, not mental health counseling. Skills building (not service brokerage) must be a part of GLI. If there is no skills building, then the intervention cannot be categorized as GLI. Service brokerage is not considered a necessary component of GLI. It is, however, a necessary component of PCM.

**What intervention type should be used to report condom drop-off activities (e.g., putting condoms in bowls in bars)?**

Condom drop-off activities should be recorded under "Other Interventions" because they do not readily fit under any other intervention type. For example, "Outreach" is not appropriate because there is no face-to-face contact with clients. "Health Communications/Public Information" is not appropriate because no information is conveyed by the drop-off activities. When interventions are reported as "Other," the intervention should be explained.

**What intervention type should be used to report brochures and other materials that health departments distribute to their grantees? What about materials they distribute to agencies they don't fund for HIV prevention?**

The recipients of the printed materials distributed by health departments do not affect the intervention type that should be used for reporting. The intervention type is "Health Communications/Public Information" (print media distribution).

**When does outreach become an individual-level intervention? For example, during outreach the outreach worker can spend a lot of time with one person on health education, risk reduction counseling, and skills building. If an ILI develops out of an outreach encounter, should health departments report on both interventions?**

If outreach develops into an intervention that meets the criteria for ILI, then both intervention types should be reported.

## Population Definitions

**How should we categorize interventions focusing on women who have sex with women (WSW)?**

WSW is not a risk population used in the Evaluation Guidance. The behavioral risk populations used in the Guidance are not intended to be exhaustive but to represent the majority of cases of transmission. For process monitoring (chapter 4), jurisdictions may report on risk populations that do not fit the categories in the Guidance in a narrative format using the variables indicated on the process monitoring forms in chapter 4 (e.g., gender, race, ethnicity, setting, etc.).

**How should jurisdictions code a population whose risk includes both MSM and IDU but the intervention is focusing specifically on MSM routes of transmission?**

Since the intervention is focusing on MSM, the primary risk population should be coded as MSM. MSM/IDU should be used to code the risk population when the intervention is designed specifically to meet the needs of men who have sex with other men and use injection drugs.

**What if the target behavior is reducing crack use?**

The question to ask for any intervention is, "What is the behavioral risk for HIV that is being addressed?" In the case of an intervention to reduce crack use, the assumption is that the behavioral risk for HIV would be sexual risk associated with crack use, either MSM or heterosexual. If this is the case, then one of these sexual risks would identify the risk population.

**Whose HIV risk is being addressed when an intervention targets the population "mother with or at risk for HIV infection?" Is it the mother, the fetus, or both?**

Regarding "Mother with/at risk for HIV," the Evaluation Guidance states, "Intervention will address the HIV prevention needs of women who have HIV or are at risk of becoming infected and who are pregnant and, thus, at risk of transmitting HIV to their infant." Therefore, if the pregnant woman is HIV- negative, the risk is for both mother and infant. If the pregnant woman is HIV- positive, the risk is for the infant. The risk population category remains "Mother with/at risk for HIV."

**How do you code populations when you have an "open" counseling intervention and anyone can use the service?**

For intervention plans, project numbers for each primary population (risk population such as MSM, IDU). For process monitoring, report the primary population as accurately as possible. Counseling implies that a risk assessment will be completed and this should help inform reporting.

**What definition should be used for heterosexual contact – there's an AIDS surveillance definition and a broader definition suggested by the Guidance?**

Use the Evaluation Guidance's broader definition. The risk population category, "heterosexual contact," does include heterosexual contact with multiple partners of unknown risk.

Also, heterosexual risk can include risk to the client as well as risk from the client (e.g., the primary population for an intervention is "heterosexual" because clients have sex with injection drug users; the primary population for an intervention is "heterosexual" because clients are HIV-infected heterosexuals).

**For the risk population categories in the Evaluation Guidance, such as MSM, is the reference to high-risk sex or any sex? Where do transgender persons or crack users fit in?**

The MSM and heterosexual behavioral risk populations defined in the Guidance reference risk; for example, MSM are at risk through unsafe sex; heterosexual men and woman are at risk through unsafe heterosexual sex. It is assumed that a jurisdiction which funds an intervention for MSM has decided that the intervention, in fact, is reaching men likely to be at risk for HIV.

Transgender persons should be counted as clients who receive a particular intervention but they are not a primary or secondary risk population according to the Evaluation Guidance. If their risk for HIV is sexual, the risk population is either heterosexual or MSM depending on their current gender identification. Similarly, crack users is not a primary or secondary population. Their risk for HIV is most likely sexual (either heterosexual or MSM).

The primary and secondary populations are the behavioral risk populations identified in the Guidance. Jurisdictions may collect data on risk populations as the jurisdiction defines those populations separate and apart from CDC's definitions.

**How should we categorize a population when the intervention is directed to a group comprised of two or more subpopulations with distinct risk behaviors; for example, an incarcerated population includes some MSM, some IDUs, and a few MSM/IDU?**

Every effort should be made to estimate a primary and secondary population in situations where an intervention targets both populations (note that data are reported only on primary populations). As a last resort, two populations that cannot be distinguished as "primary" and "secondary" should be reported separately as two primary populations. Because the members of

the group cannot be distinguished by risk, the full population should be counted in each primary population report (i.e., they will be double-counted).

A jurisdiction may "split" the population for local reporting, but must be careful to match the specificity of the intervention plan reporting to that of process monitoring; i.e., if the population is split for intervention plan estimation, then it should be split for process monitoring reporting.

**Why does the CDC strategic plan discuss "youth" as a priority population when this is not a risk population in the Guidance?**

With the exception of "Mother with/at risk for HIV" and "General Population," the Guidance uses behavioral risk population categories (i.e., MSM, MSM/IDU, IDU, and heterosexual) because intervention types are used to influence particular risky behaviors that transmit HIV disease. CDC's strategic plan discusses youth because interventions should be targeted at the risky behaviors youth engage in. Data on youth served should be provided under the age range categories for intervention plans and process monitoring. In a similar vein, the prevention needs of HIV-infected persons are discussed in the strategic plan but HIV- infected persons are not a risk population category in the Guidance. Health departments are encouraged to fund programs that serve youth and HIV-infected persons, but the data to be submitted to CDC should reflect the risk population categories of the Guidance.

**Is there a time-frame for specifying risk behaviors? For example, if someone has used needles in the past, does it have to be in the past year (or 6 months or 3 months) for them to be reported as an IDU? Does the time frame vary for different behaviors?**

Agencies will likely have their own policies on conducting a risk assessment or otherwise determining risk behaviors. Current risk behaviors are most important because interventions will target behaviors clients are currently engaged in.

## Process Monitoring

**On the process monitoring forms in regard to staffing and expenditures, do you want to know the number of volunteers or the number of volunteer hours?**

The number of volunteers providing interventions should be reported regardless of the amount of time they volunteer.

**The process monitoring forms ask for the number of clients receiving interventions in various settings. The instructions indicate that a "Clinic/Health Care Facility" includes an STD clinic, but the form has "STD Clinic" as a separate setting. How will this discrepancy be resolved?**

The instructions will be revised to match the forms. "Clinic/Health Care Facility" will not include an STD clinic. (The instructions also refer to "Social Services Agency" but there is no

corresponding designation on the form under type of setting. For social services agency, the "other" designation should be used.)

**If an intervention reaches clients other than those intended by the intervention, how are these clients reported for process monitoring? For example, if street outreach intends to target IDUs, but outreach workers also encounter a lot of high risk heterosexuals, how is the heterosexual population reported on the process monitoring forms?**

The process monitoring forms should contain data on the primary risk populations being served by the intervention. Data are not reported on secondary risk populations. It is possible that new primary risk populations will be added to an intervention type over time, and health departments should provide data on them when process monitoring data are due. If you find that you are serving different populations than the ones you originally planned to serve in your intervention plans, you should report process monitoring data about that new population if you redesigned your intervention to accommodate the new population or the new clients you are serving total at least 25% of your caseload. In regard to the question's example, if the heterosexual population comprises roughly 25% or more of the population reached during outreach, then process monitoring data should be provided on that population.

**Should clients who attend only one session of a GLI be reported under GLI or ILI?**

Group-level interventions (GLIs) should consist of multiple sessions. There will undoubtedly be cases where clients do not attend all of the sessions. Clients who attend only one session of a GLI should be reported under GLI and not ILI since GLI was the intervention being delivered.

**Can you report risk populations for process monitoring based on the intended audience for the intervention or do you need to assess participants' risk? For example, if 10 people participate in a GLI targeting MSM, can you report that you reached 10 MSM if you do not collect data on their risk behaviors?**

For some intervention types, it is appropriate for the interventionist to conduct a risk assessment. For example, a risk assessment should always be completed for clients in PCM, and CDC strongly encourages risk assessments for other interventions as well. When there is no risk assessment, the intent of the intervention should guide reporting for process monitoring. If the intent of GLI, for example, is to serve MSM and there is no risk assessment to document the risk behavior, then clients should be reported as MSM since the intervention is targeted and tailored for MSM. Since risk assessments are not done during outreach, the venue for the outreach should be considered. For example, if outreach is taking place in gay bars, then the risk population should be reported as MSM. If no specific risk population is targeted by an intervention (this could be the case for health communications/public information), then "General Population" should be used as the risk population category.

**How do you report the number of clients served if a contractor conducts teacher training with the intention that the teachers will then provide prevention education to their students? How do you report the risk population and demographics in this scenario?**

In this scenario, health communications/public information seems to be the intended intervention. Students are the targeted population and there is probably no one risk behavior that is targeted. If this is the case, "General Population" would be the risk population. However, the numbers of clients served cannot be reported until those data are provided, in writing, by the teachers who received training. The teachers should report back to the Contractee after their prevention education session takes place. If the intervention is designed to address heterosexual contact as the risk, then that risk population category should be used for reporting when data are provided by the teachers.

**How should health departments characterize the type of agency delivering the intervention (item #6 on process monitoring forms) when the intervention is conducted by an agency sub-contracted by the health department's grantee? Should the agency type be coded as the health department's grantee or the agency sub-contracted by the grantee?**

The intent is to capture data on the types of agencies actually carrying out interventions. Therefore, the agency that has been sub-contracted by the health department's grantee should be used for agency type.

## Outcome Evaluation

**Can you use proxy measures for behavior change for outcome evaluation such as attitudes, beliefs, norms, or behavioral intentions or do you need to measure actual behavior change?**

Since the ultimate objective of HIV prevention is to change risky behaviors, measures of behavior change are preferred for outcome evaluation. However, measures of change in knowledge, attitudes, beliefs, norms, or intentions are acceptable.

## Use of Evaluation Data

**How will data be used and how will CDC guard against misuse?**

The Evaluation Guidance states that data provided by health departments will be used for three purposes: 1) To report to federal, state, and local stakeholders (including communities, health departments, local and national organizations, and federal policymakers) progress made through HIV prevention programs supported by CDC funds; 2) To improve national policies regarding HIV prevention; 3) To identify ways to improve HIV prevention programs nationwide.

CDC is interested in aggregate, national-level data. It is not CDC's intent to use local data in a punitive way. Data are collected and analyzed for the purpose of program improvement. State-level data will be shared with project officers. State-level data will not be shared with persons outside of CDC without consultation and discussion with state health department officials.

**Interventions may vary within a jurisdiction; for example, prevention case management may be carried out with varying levels of intensity throughout a state. Will data on interventions at the jurisdiction-level be pooled together in a national data set?**

Yes, data on interventions will be pooled together, with the acknowledgment of differences in how interventions are delivered. Health departments may provide narrative to explain variations in interventions.

**Will CDC change its funding formula to reflect the effectiveness of interventions. In other words, will jurisdictions get more money if their interventions are effective?**

CDC does not foresee linking funding to empirically demonstrated effectiveness.

**Will CDC penalize jurisdictions who report reaching fewer people if that is the result of efforts to more specifically target their interventions to certain risk behaviors?**

No. This would be seen as improving interventions, and large numbers are not necessarily a measure of success.

## Relationship Between the Guidance, Other Evaluation Efforts, and CDC Program Announcements

**Will the Evaluation Guidance being developed for CBOs be different from the Evaluation Guidance for health departments?**

The CBO Evaluation Guidance -- a document on HIV/AIDS prevention program evaluation for CBOs directly funded by CDC -- is under development, and health department representatives are involved. The intent is that the CBO Guidance be as consistent as possible with the Evaluation Guidance for health departments, including consistency between the data to be collected from directly funded CBOs and the data collected from health department grantees.

**How does the Evaluation Guidance relate to evaluation of the whole health department?**

The Evaluation Guidance pertains to prevention programs currently funded under Program Announcement 99004. The ideas, principles, and methods outlined in the Guidance may also be useful for evaluating prevention and/or care activities undertaken with state or city revenues, with other federal funds, or with other resources. However, the Evaluation Guidance does not ask that efforts funded outside of CDC cooperative agreement funds be evaluated.

Health departments may be asked by funders other than CDC for HIV/AIDS program evaluation. The Program Evaluation Research Branch (PERB) is working with other branches in CDC and with HRSA to develop a common language for evaluation; for example, by standardizing definitions of populations and interventions.

**Will CDC reconcile Program Announcement and Evaluation Guidance requests?**

PERB and PBB are working together to reconcile any differences between program announcements and the Evaluation Guidance, including differences in the definitions of interventions and populations.

**How will CDC reinforce the message that the Guidance intervention definitions will apply to future activities?**

PERB is working to standardize definitions of interventions and populations. However, it is important to note that definitions in the Evaluation Guidance do not have to replace local taxonomies. Jurisdictions may use definitions of interventions and populations already in place locally. They just need to make sure local taxonomies are used consistently and that they fit categories in the Guidance.

**What is the relationship between external reviews and progress reports?**

Progress reports submitted in April will undergo a "technical review" by project officers. However, external reviewers may have the opportunity to refer to progress reports.

**How do differences between Evaluation Guidance definitions for risk populations and surveillance definitions for exposure category relate to how budget tables are viewed? Are budget tables compared to surveillance data?**

Chapter 5 of the Evaluation Guidance discusses the importance of linkages between the comprehensive HIV prevention plan and the allocation of resources. "Epi" or surveillance data should inform the prevention plan and there should be a strong and logical linkage between the plan and interventions and populations that get funded. PERB and PBB are discussing how Evaluation Guidance data, including budget tables and surveillance/ "Epi" data in the comprehensive plan, will be reviewed with the objective of improving community planning and prevention programming.

**Can process monitoring data regarding expenditures replace the budget tables?**

No. At this time, budget tables will continue to be submitted, but in April, rather than September. The form will be revised for health departments to reflect actual expenditures, to the extent possible. The revised table will be due in April 2001 to reflect the period, January - December 2000.

**What is the implication/cost for doing evaluation in rural areas – is there a "ruralness" factor?**

The Division of HIV/AIDS Prevention appreciates the challenges for program evaluation in rural areas, plans to discuss the issue, and will request feedback from rural states.

## Technical Assistance

**What additional tools are available to help with evaluation and community planning?**

Technical assistance (TA) requests concerning community planning and the Evaluation Guidance should go through the health department's CDC project officer. CDC supports several organizations to provide community planning TA. This network is coordinated by CDC with assistance from the Academy for Educational Development.

**What software can be used to manage data? Will CDC develop software for health departments?**

Technical assistance channeled through project officers can put health departments in touch with other jurisdictions that have developed software to collect and/or aggregate data from their grantees (CBOs). CDC has plans to develop software that health departments can use to report aggregated data to CDC. In addition, CDC has developed a website that contains the Evaluation Guidance (Volumes 1 and 2) and other materials on evaluation. Health departments can download forms from the Evaluation Guidance to record the data asked for in the Guidance. The website address is http://www.cdc.gov/hiv/aboutdhap/perb/hdg.htm.

## Appendix

This appendix contains examples of resource materials referenced in the manual. These materials are listed below along with their sources, page number of the manual where they are discussed, and page number of the appendix where they are located. Health departments approved inclusion of their materials in this manual. These resources were selected for their clarity and because they represent a variety of approaches for Guidance implementation. Health departments are encouraged to adapt and use these materials as needed.

This manual did **not** attempt a comprehensive review of Guidance-related materials developed and used by all health departments. Therefore, readers should not assume that materials included in this appendix are necessarily better than other materials currently being used by health departments. More recent versions of these materials may have been developed by health departments after this manual was produced.

| **Resource Materials** | **Source** | **Page Number in Manual Where Material is Discussed** | **Page Number in Appendix Where Material is Located** |
|---|---|---|---|
| Intervention plan worksheet | Colorado | 19 | 80 |
| Intervention plan worksheet | Virginia | 19 | 81 |
| Intervention plan worksheet | Wisconsin | 19 | 82 |
| Definitions that distinguish client "contact" and "interaction" | Wisconsin | 21 | 83 |
| Summary of behavioral science theories | CDC | 23, 27 | 84 |
| Logic model training curriculum | Maryland | 27 | 85 |
| Intervention standards | Colorado | 28 | 86 |
| Data collection form | Wisconsin | 31 | 87 |
| Data collection form | Virginia | 31 | 88 |
| Data collection forms | Maryland | 31 | 89 |
| Data collection form | New Jersey | 31 | 90 |
| Client code sign in sheet | Maryland | 38 | 91 |

## Intervention Plan Worksheet, Colorado

**PREVENTION CASE MANAGEMENT (PCM): FORM**

a. A separate intervention plan must be completed for each intervention level for each population. Please review the instructions before completing the form.
b. Please be as brief as possible. Your intervention plan should not exceed 7 pages in total.

**(1) AGENCY INFORMATION:**

Agency name:
Name of primary contact for this document:
Phone: Email:
Funding amount for this intervention: All sources:$ AIDS Program:$

**(2) PROGRAM NAME:**
**INTERVENTION PLAN CODE:**

**(3) POPULATIONS TO BE SERVED**

| **Primary** (check only one – replace with X) | **Secondary** (check only one or none) |
|---|---|
| ❍ MSM | ❍ MSM |
| ❍ MSM/IDU | ❍ MSM/IDU |
| ❍ IDU | ❍ IDU |
| ❍ Heterosexual risk | ❍ Heterosexual risk |
| ❍ General population | ❍ General population |

**(4) CLIENTS TO BE SERVED**

| | Gender | | | Age Group | | | | Race/Ethnicity | | | | | HIV status | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | Male | Female | Trans-gender | <19 | 19-24 | 25-29 | 30+ | Am. Indian | Asian/ PI | Black /AA | Hispanic/ Latino | White | HIV+ | HIV- or unknown |
| | | | | | | | | | | | | | | |

Description

**(5A) INTERVENTION:** **X** Prevention Case Management

**(5B) CORE REQUIREMENTS FOR THIS INTERVENTION:**
If funded to conduct PCM, a grantee must meet all the requirements outlined in the Guidelines section for this intervention. Specifically describe how your agency will address each of the requirements listed in the instructions for this section.

**(6) BASIS AND OUTCOMES OF THE INTERVENTION**

**(6A) Identified need for reaching the specified population:**

**(6B) Evidence basis for the intervention:**

**(6C) Justification for using this intervention for the specified population:**

| (6D) Anticipated measurable outcomes: | Number of clients |
|---|---|
| Total number of people to be contacted for PCM | |
| Number engaging in an initial PCM session (same as Total Clients in Section 4A) | |
| Number receiving at least 3 sessions | |
| Number completing an initial Behavioral Risk Assessment Tool (BRAT) (near intake) | |
| Number completing a second BRAT (at 2 months) | |
| Number with some sexual or drug risk behavior change between BRAT 1 and 2, as evidenced on the BRAT | |
| Number with some behavior change as noted in chart (but not necessarily captured on BRAT) | |
| Number completing a third BRAT or more | |
| Number with evidence of maintenance of sexual or drug risk behavior change based upon 3rd BRAT | |
| Of clients in PCM, number linked to care and treatment (those previously linked and linked as result of entering PCM) | |
| Additional measurable outcomes | |
| | |
| | |
| | |
| | |

| (7) SERVICE PLAN DESCRIPTION | | |
|---|---|---|
| **(7A) Service delivery** | | |
| Service delivery model (i.e. frequency, method to reach people, etc): Include all strategies. | | |
| Time of day: | | |
| Service area: | | |
| Setting/location: | | |
| Content/messages: | | |
| **(7B) Staffing issues** | | |
| Number of FTE (full time equivalent) staff providing the intervention: | FTEs with all funds | FTEs with AIDS Program funds |
| Number of volunteers (individuals, not FTEs) assisting with the intervention. | | |
| Staff background and experience with risk population: | | |
| Staff training and development: | | |
| Supervision: | | |

| | |
|---|---|
| **(7C) Data collection and evaluation:** | |
| **(7D) Referral sources** – into your services | **Referrals** – to other services |

| **(7E) Work plan steps:** | **Key dates:** |
|---|---|
| Needs assessment and program development: | |
| Hiring/training: | |
| Services begin: | |
| Other: | |

**Table 3. Process/Outcome Objectives:**

| |
|---|
| **1. Process Objective #1:** |
| **2. Process Objective #2:** |
| **3. Outcome Objective #1:** |
| **4. Outcome Objective #2:** |

## Table 4. County Demographics

| **County Demographics**‡ (M=male; F=female; T=transgender; NT=gender not targeted) | **≤ 19 years old** | | | | **20-29 years old** | | | | **30+ years old** | | | | **Age data not available** | | | | **TOTAL** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | T | NT | M | F | T | NT | M | F | T | NT | M | F | T | NT | |
| *American Indian/Alaska Native* | | | | | | | | | | | | | | | | | |
| *Asian/Pacific Islander* | | | | | | | | | | | | | | | | | |
| *Black* | | | | | | | | | | | | | | | | | |
| *Latino/Hispanic* | | | | | | | | | | | | | | | | | |
| *White* | | | | | | | | | | | | | | | | | |
| *Other* | | | | | | | | | | | | | | | | | |
| **Total** | | | | | | | | | | | | | | | | | |

‡ The minimum data required for this report are the totals contained in the double-lined boxes (gender & race/ethnicity) at the far right of the table above. Completing the other cells is optional but encouraged. The exception to this is if your intervention targets a specific age group. In that instance, age data MUST be supplied.

## Table 5. Volunteer/Staff Demographics

| **Volunteer/Staff**‡ (M=male; F=female; T=transgender; NT=gender not targeted) | **≤ 19 years old** | | | | **20-29 years old** | | | | **30+ years old** | | | | **Age data not available** | | | | **TOTAL** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | T | NT | M | F | T | NT | M | F | T | NT | M | F | T | NT | |
| *American Indian/Alaska Native* | | | | | | | | | | | | | | | | | |
| *Asian/Pacific Islander* | | | | | | | | | | | | | | | | | |
| *Black* | | | | | | | | | | | | | | | | | |
| *Latino/Hispanic* | | | | | | | | | | | | | | | | | |
| *White* | | | | | | | | | | | | | | | | | |
| *Other* | | | | | | | | | | | | | | | | | |
| **Total** | | | | | | | | | | | | | | | | | |

‡ The minimum data required for this report are the totals contained in the double-lined boxes (gender & race/ethnicity) at the far right of the table above. Completing the other cells is optional but encouraged. The exception to this is if your intervention targets a specific age group. In that instance, age data MUST be supplied.

## Table 6. Clients to be Served Demographics

| **Clients To Be Served**[‡] (M=male; F=female; T=transgender; NT=gender not targeted) | **≤ 19 years old** | | | | **20-29 years old** | | | | **30+ years old** | | | | **Age data not available** | | | | **TOTAL** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | T | NT | M | F | T | NT | M | F | T | NT | M | F | T | NT | |
| *American Indian/Alaska Native* | | | | | | | | | | | | | | | | | |
| *Asian/Pacific Islander* | | | | | | | | | | | | | | | | | |
| *Black* | | | | | | | | | | | | | | | | | |
| *Latino/Hispanic* | | | | | | | | | | | | | | | | | |
| *White* | | | | | | | | | | | | | | | | | |
| *Other* | | | | | | | | | | | | | | | | | |
| **Total** | | | | | | | | | | | | | | | | | |

[‡] The minimum data required for this report are the totals contained in the double-lined boxes (gender & race/ethnicity) at the far right of the table above. Completing the other cells is optional but encouraged. The exception to this is if your intervention targets a specific age group. In that instance, age data MUST be supplied.

## Intervention Plan Worksheets, Virginia

# ANNUAL PLAN: WORKSHEET 1 – LIST OF HIV INTERVENTIONS

**Agency Name**: _____ **Dates covered:** _____

**Grant Program**: (*check only one*)
- ❑ AIDS Service Organizations
- ❑ AIDS Services and Education
- ❑ Community Collaboration
- ❑ High Risk Youth and Adults
- ❑ Prevention Case Management
- ❑ Faith Initiative
- ❑ Minority Projects
- ❑ MSM HIV Prevention

**Agency type:** (*check one only*)
- ❑ CBO – Minority Board
- ❑ CBO – Non-Minority Board
- ❑ State Health Department
- ❑ Local Health Department
- ❑ Other Government
- ❑ Academic Institution
- ❑ Research Center
- ❑ Faith Community
- ❑ Individual
- ❑ Other (_____)

| INTERVENTION(S) THAT WILL BE IMPLEMENTED UNDER THE ABOVE GRANT | CHECK IF YOU WILL IMPLEMENT | HOW MANY OF EACH TYPE OF INTERVENTION WILL YOU IMPLEMENT? (indicate # and complete same # of worksheets.) |
|---|---|---|
| **Counseling and Testing** | | |
| Counseling and Testing | ❑ | |
| Referral | ❑ | |
| Partner Counseling and Referral services | ❑ | |
| Other (specify) | ❑ | |
| **Health Education/Risk Reduction** | | |
| Individual Level Intervention (ILI) | ❑ | |
| Prevention Case Management (PCM) | ❑ | |
| Community Level Intervention | ❑ | |
| Group Level Intervention (GLI) | ❑ | |
| **OUTREACH:** | | |
| Basic Street/Community Outreach | ❑ | |
| Intensive Street/Community Outreach | ❑ | |
| Facilitative Street/Community Outreach | ❑ | |
| Collaborative Street/Community Outreach | ❑ | |
| **Health Communication/Public Information** | | |
| Presentations/Lectures (ONLY LIST NUMBER OF TYPES/SERIES – NOT INDIVIDUAL SESSIONS) | ❑ | |
| Health/Community Fairs | ❑ | |
| Social Marketing | ❑ | |
| Mass Media | ❑ | |
| Hotlines | ❑ | |
| Clearinghouse | ❑ | |

# ANNUAL PLAN WORKSHEET 2a:
## Counseling and Testing
## Intervention Information Worksheet

Agency Name: _____ Intervention Name: _____

Target Population for this Intervention (From Workplan): _____ Process Objective for this Intervention (number): _____

| Category (check one only) | Activities (check all that apply) | Setting | Targets for Intervention |
|---|---|---|---|
| ☐ Counseling and Testing<br>☐ Referral<br>☐ Partner Counseling and Referral services<br>☐ Other _____ | If Testing, which type:<br>☐ Blood test<br>☐ Alternate (Orasure)<br>If Referrals, which are primary sites:<br>☐ STD clinic<br>☐ HIV counseling and testing<br>☐ Tuberculosis clinic<br>☐ Drug treatment<br>☐ Family planning<br>☐ Mental health<br>☐ HIV early intervention<br>☐ Other medical services<br>☐ Entitlement program<br>☐ Job skills / acquisition<br>☐ Prevention case management<br>☐ Individual-level counseling<br>☐ Group-level counseling<br>☐ Other _____ | ☐ Medical<br>☐ Workplace<br>☐ School<br>☐ Street<br>☐ Bars<br>☐ Community Center<br>☐ Church/faith<br>☐ Home<br>☐ Shelter<br>☐ Drug treatment<br>☐ Correctional<br>☐ Other: _____ | **Risk Behaviors** — PRIMARY / SECONDARY<br>MSM ☐ ☐<br>IDU ☐ ☐<br>MSM/IDU ☐ ☐<br>Heterosexual Contact ☐ ☐<br>Pregnant women (with/at risk of HIV) ☐ ☐<br>No specific targeted risk ☐<br><br>**Populations (check all that apply)**<br>Racial/ethnic minorities ☐<br>Men who have sex with men ☐<br>Women ☐<br>Youth ☐<br>PWH/As ☐<br>Homeless ☐<br>Sex Workers ☐<br>Mentally Dysfunctional ☐<br>Inmates ☐<br>General Population ☐ |
| **Estimated number of:**<br>____ HIV-infected clients<br>____ Partners identified<br>____ Partners notified<br>____ Partners counseled<br>____ Partners tested | | | |

## ESTIMATED NUMBER OF CLIENTS TO BE SERVED

| | ≤ 19 years old | | | | 20 – 29 years old | | | | 30 + years old | | | | Age Data Not Available | | | | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Trans-gender | Not Target. | Male | Female | Trans-gender | Not Target. | Male | Female | Trans-gender | Not Target. | Male | Female | Trans-gender | Not Target. | |
| American Indian or Alaskan Native | | | | | | | | | | | | | | | | | |
| Asian | | | | | | | | | | | | | | | | | |
| Black or African-American | | | | | | | | | | | | | | | | | |
| Native Hawaiian/Other Pacific Isl. | | | | | | | | | | | | | | | | | |
| White | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | |
| **TOTAL RACE** | | | | | | | | | | | | | | | | | |
| Hispanic/Latino(a) | | | | | | | | | | | | | | | | | |
| Non-Hispanic | | | | | | | | | | | | | | | | | |
| **TOTAL ETHNICITY** | | | | | | | | | | | | | | | | | |

☆ ***The minimum data required for this report are the totals contained in the shaded boxes at the far right end of the table above. Completing other cells is optional but encouraged.***

# ANNUAL PLAN: WORKSHEET 2b:

## Health Education/Risk Reduction Intervention Information Worksheet

Agency Name:_____ Intervention Name: _____

Target Population for this Intervention (From Workplan): _____ Process Objective for this Intervention (number): _____

| Category (check one only) | Setting | Frequency of Contact | Targets for Intervention | Primary Objective (check one only) |
|---|---|---|---|---|
| ☐ Individual Level Intervention<br>☐ Prevention Case Management (PCM)<br>☐ Group Level Intervention<br>☐ Community Level Intervention<br>**OUTREACH:**<br>☐ Basic Street/ Community Outreach<br>☐ Intensive Street/ Community Outreach<br>☐ Facilitative Street/ Community Outreach<br>☐ Collaborative Street/ Community Outreach | ☐ Medical<br>☐ Workplace<br>☐ School<br>☐ Street<br>☐ Bars<br>☐ Community Center<br>☐ Church/faith<br>☐ Home<br>☐ Shelter<br>☐ Drug treatment<br>☐ Correctional<br>☐ Other: _____ | Are there multiple components/ sessions for this intervention?<br>☐ Yes → how many? _____<br>☐ No, single component<br>How many times will this intervention be repeated in the year?<br>_____ times<br>☐ Ongoing<br>☐ Don't know | **Risk Behaviors** — PRIMARY — SECONDARY<br>MSM ☐ ☐<br>IDU ☐ ☐<br>MSM/IDU ☐ ☐<br>Heterosexual Contact ☐ ☐<br>Pregnant women (with/at risk of HIV) ☐ ☐<br>No specific targeted risk ☐<br>**Populations (check all that apply)**<br>Racial/ethnic minorities ☐<br>Men who have sex with men ☐<br>Women ☐<br>Youth ☐<br>PWH/As ☐<br>Homeless ☐<br>Sex Workers ☐<br>Mentally Dysfunctional ☐<br>Inmates ☐<br>General Population ☐ | ☐ Increased awareness of HIV and AIDS<br>☐ New knowledge of AIDS and HIV transmission modes<br>☐ Changed attitudes or values<br>☐ Change in self-perception of risk<br>☐ Increased protective behaviors<br>☐ Maintenance of behaviors<br>☐ Reduction of risk behaviors<br>☐ Elimination of risk behaviors<br>☐ Other: _____ |

## ESTIMATED NUMBER OF CLIENTS TO BE SERVED

| | ≤ 19 years old | | | | 20 – 29 years old | | | | 30 + years old | | | | Age Data Not Available | | | | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Trans-gender | Not Target. | Male | Female | Trans-gender | Not Target. | Male | Female | Trans-gender | Not Target. | Male | Female | Trans-gender | Not Target. | |
| American Indian or Alaskan Native | | | | | | | | | | | | | | | | | |
| Asian | | | | | | | | | | | | | | | | | |
| Black or African-American | | | | | | | | | | | | | | | | | |
| Native Hawaiian/Other Pacific Isl. | | | | | | | | | | | | | | | | | |
| White | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | |
| **TOTAL RACE** | | | | | | | | | | | | | | | | | |
| Hispanic/Latino(a) | | | | | | | | | | | | | | | | | |
| Non-Hispanic | | | | | | | | | | | | | | | | | |
| **TOTAL ETHNICITY** | | | | | | | | | | | | | | | | | |

☆ ***The minimum data required for this report are the totals contained in the shaded boxes at the far right end of the table above. Completing other cells is optional but encouraged.***

# ANNUAL PLAN: WORKSHEET 2c:
## Health Communication/Public Information
### Intervention Information Worksheet

revised 5/09/01

Agency Name:_____ Intervention Name: _____

Target Population for this Intervention (From Workplan): _____ Process Objective for this Intervention (number): _____

| Category (check one only) | Method | Frequency of Contact | Targets for Intervention | Primary Objective (check one only) |
|---|---|---|---|---|
| ☐ Presentations/lectures<br>☐ Health/Community Fairs<br>☐ Social Marketing<br>☐ Mass Media<br>☐ Hotlines<br>☐ Clearinghouse | ☐ Electronic media<br>☐ Print media<br>☐ Clearinghouse<br>☐ Other _____<br><br>**Partners: (# of)**<br>___ Individuals<br>___ Businesses<br>___ Agencies/ organizations<br>___ Media Outlets | How many times will this intervention be repeated in the year?<br>_____ times<br>☐ Ongoing<br>☐ Don't know | **Risk Behaviors** — PRIMARY / SECONDARY<br>MSM ☐ ☐<br>IDU ☐ ☐<br>MSM/IDU ☐ ☐<br>Heterosexual Contact ☐ ☐<br>Pregnant women (with/at risk of HIV) ☐ ☐<br>No specific targeted risk ☐<br><br>**Populations (check all that apply)**<br>Racial/ethnic minorities ☐<br>Men who have sex with men ☐<br>Women ☐<br>Youth ☐<br>PWH/As ☐<br>Homeless ☐<br>Sex Workers ☐<br>Mentally Dysfunctional ☐<br>Inmates ☐<br>General Population ☐ | ☐ Increased awareness of HIV and AIDS<br>☐ New knowledge of AIDS and HIV transmission modes<br>☐ Changed attitudes or values<br>☐ Change in self-perception of risk<br>☐ Increased protective behaviors<br>☐ Maintenance of behaviors<br>☐ Reduction of risk behaviors<br>☐ Elimination of risk behaviors<br>☐ Other: _____ |

**ESTIMATED NUMBER OF CLIENTS TO BE SERVED**

| | ≤ 19 years old | | | | 20 – 29 years old | | | | 30 + years old | | | | Age Data Not Available | | | | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Trans-gender | Not Target. | Male | Female | Trans-gender | Not Target. | Male | Female | Trans-gender | Not Target. | Male | Female | Trans-gender | Not Target. | |
| American Indian or Alaskan Native | | | | | | | | | | | | | | | | | |
| Asian | | | | | | | | | | | | | | | | | |
| Black or African-American | | | | | | | | | | | | | | | | | |
| Native Hawaiian/Other Pacific Isl. | | | | | | | | | | | | | | | | | |
| White | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | |
| **TOTAL RACE** | | | | | | | | | | | | | | | | | |
| Hispanic/Latino(a) | | | | | | | | | | | | | | | | | |
| Non-Hispanic | | | | | | | | | | | | | | | | | |
| **TOTAL ETHNICITY** | | | | | | | | | | | | | | | | | |

☆ *The minimum data required for this report are the totals contained in the shaded boxes at the far right end of the table above. Completing other cells is optional but encouraged.*

## Intervention Plan Worksheets, Wisconsin

**PREVENTION CASE MANAGEMENT (PCM): FORM**

a. A separate intervention plan must be completed for each intervention level for each population. Please review the instructions before completing the form.
b. Please be as brief as possible. Your intervention plan should not exceed 7 pages in total.

**(1) AGENCY INFORMATION:**

Agency name:
Name of primary contact for this document:
Phone: Email:
Funding amount for this intervention: All sources:$ AIDS Program:$

**(2) PROGRAM NAME:**
**INTERVENTION PLAN CODE:**

**(3) POPULATIONS TO BE SERVED**

| **Primary** (check only one – replace with X) | **Secondary** (check only one or none) |
|---|---|
| ❍ MSM | ❍ MSM |
| ❍ MSM/IDU | ❍ MSM/IDU |
| ❍ IDU | ❍ IDU |
| ❍ Heterosexual risk | ❍ Heterosexual risk |
| ❍ General population | ❍ General population |

**(4) CLIENTS TO BE SERVED**

| | Gender | | | Age Group | | | | Race/Ethnicity | | | | | HIV status | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | Male | Female | Trans-gender | <19 | 19-24 | 25-29 | 30+ | Am. Indian | Asian/ PI | Black /AA | Hispanic/ Latino | White | HIV+ | HIV- or unknown |
| | | | | | | | | | | | | | | |

Description

**(5A) INTERVENTION:** **X** Prevention Case Management

**(5B) CORE REQUIREMENTS FOR THIS INTERVENTION:**
If funded to conduct PCM, a grantee must meet all the requirements outlined in the Guidelines section for this intervention. Specifically describe how your agency will address each of the requirements listed in the instructions for this section.

**(6) BASIS AND OUTCOMES OF THE INTERVENTION**

**(6A) Identified need for reaching the specified population:**

**(6B) Evidence basis for the intervention:**

**(6C) Justification for using this intervention for the specified population:**

| (6D) Anticipated measurable outcomes: | Number of clients |
|---|---|
| Total number of people to be contacted for PCM | |
| Number engaging in an initial PCM session (same as Total Clients in Section 4A) | |
| Number receiving at least 3 sessions | |
| Number completing an initial Behavioral Risk Assessment Tool (BRAT) (near intake) | |
| Number completing a second BRAT (at 2 months) | |
| Number with some sexual or drug risk behavior change between BRAT 1 and 2, as evidenced on the BRAT | |
| Number with some behavior change as noted in chart (but not necessarily captured on BRAT) | |
| Number completing a third BRAT or more | |
| Number with evidence of maintenance of sexual or drug risk behavior change based upon 3rd BRAT | |
| Of clients in PCM, number linked to care and treatment (those previously linked and linked as result of entering PCM) | |
| Additional measurable outcomes | |
| | |
| | |
| | |
| | |

| (7) SERVICE PLAN DESCRIPTION | | |
|---|---|---|
| **(7A) Service delivery** | | |
| Service delivery model (i.e. frequency, method to reach people, etc): Include all strategies. | | |
| Time of day: | | |
| Service area: | | |
| Setting/location: | | |
| Content/messages: | | |
| **(7B) Staffing issues** | | |
| Number of FTE (full time equivalent) staff providing the intervention: | FTEs with all funds | FTEs with AIDS Program funds |
| Number of volunteers (individuals, not FTEs) assisting with the intervention. | | |
| Staff background and experience with risk population: | | |
| Staff training and development: | | |
| Supervision: | | |

| | |
|---|---|
| **(7C) Data collection and evaluation:** | |
| **(7D) Referral sources** – into your services | **Referrals** – to other services |

| **(7E) Work plan steps:** | **Key dates:** |
|---|---|
| Needs assessment and program development: | |
| Hiring/training: | |
| Services begin: | |
| Other: | |

## Definitions that Distinguish Client “Contact” and “Intervention”, Wisconsin

DEFINITIONS

**Contacts and Interactions**

These concepts were first implemented in Wisconsin through the 2000 Participant Data Form. The two terms distinguish levels of intensity involved in each intervention.

**Contacts**: These are generally either relatively brief in nature or occur in a group setting. Examples of contacts include:

- brief conversations in the context of street and community outreach or at events such as health fairs;
- one-time presentations to groups, including by teen peers ;
- hotline calls;
- distribution of brochures and condoms.

**Interactions**: Staff interact with a client on an intensive and usually repeated basis. In an interaction, staff have a conversation with the client in which the client may identify his or her risk behaviors for HIV, and the staff and client identify strategies for reducing the client's risk behaviors. Examples include:

- risk reduction counseling;
- prevention case management;
- ongoing groups that specifically address risk behaviors;
- repeated encounters in a street outreach setting.

**Clarification of the distinction between contacts and interactions**

- Presentations in correctional settings should be counted as **interactions** if the same group of inmates participates in several sessions over time. If each time a staff person presents in a correctional facility, it is to a new group of inmates, these presentations should be counted as **contacts**.
- Street outreach encounters should be counted as **contacts** unless an outreach worker has multiple encounters with the same individual, thereby developing a relationship that may lead the client to change risk behaviors or seek services.

**Skills building component** – For an intervention to qualify as having a skills building component, participants *must* be able to demonstrate attainment of a skill taught through the intervention. For example, a presenter demonstrating how to put a condom on a model *is not* an example of a skills building component. If the participants each demonstrate individually how to put a condom on a model, negotiate safer sex, or disclose HIV serostatus, the intervention *would* include a skills building component. As a reminder, to qualify as an **interaction**, an intervention must include a skills building component.

## INTERVENTION DESCRIPTIONS

| INTERVENTION TYPE | LEVEL OF INTENSITY* | THIS INCLUDES..... | THIS DOES NOT INCLUDE..... |
|---|---|---|---|
| **Individual Level Intervention (ILI)** | I | Risk reduction counseling with a skills building component provided to 1 person at a time | • Outreach (has its own category)<br>• Prevention case management (has its own category) |
| **Group Level Intervention (GLI)** | I | Risk reduction counseling with a skills building component provided to more than 1 person at a time, usually multi-session | • "1-shot" educational presentations<br>• Lectures |
| **Outreach** | C | Educational interventions conducted face-to-face in places where clients congregate, includes needle exchange | • Lectures or group educational presentations<br>• Outreach solely for the purpose of counseling and testing (CTS) |
| **Prevention Case Management (PCM)** | I | HIV prevention case management (PCM) combines individual risk reduction counseling with an individualized case plan developed by the client and service provider and implementation of the plan including referrals. PCM concentrates on providing prevention education and risk reduction counseling through intensive one-on-one, client-centered interaction. | On-on-one counseling with a skills building component that does not include a written plan for risk reduction and referrals to other services needed by the client (ILI) |
| **Partner Counseling and Referral Services (PCRS)** | C or I | Systematic notification of sex/needle sharing partners of HIV+ individuals | Counseling and testing services (has its own category) |
| **Counseling and Testing Services (CTS)** | C or I | Individualized risk reduction counseling and testing for HIV antibodies | • PCRS<br>• Treatment for HIV<br>• Testing of and treatment for STIs |
| **Health Communication Public Information (HC/PI)** | C | Use of electronic or print media, educational presentations or lectures, hotlines, or clearinghouses to deliver planned prevention messages to support risk-reduction, provide information, increase awareness, or build support for safe behavior | Group interventions with a skills building component (GLI) |
| **Capacity Building** | N | Efforts assist other agencies or targeted communities in expanding the quantity, quality, and comprehensiveness of the services provided | |
| **Other** | C or I | Interventions not easily classified under the above categories, such as those involving direct prevention linkages to AODA treatment, school-based diversity programs, and community level interventions (CLI) | Interventions without scientific evidence and/or justification for application to the target population and setting |

*C=contact, I=intervention, N=neither See definitions for **contacts** and **interactions** that precede the table.

**Summary of Behavioral Science Theories, Handbook for HIV Prevention Community Planning, CDC, 1994**

# Appendix A
# Behavioral Science Theory

## Introduction

A general understanding of the behavioral and social science theory underlying the development of behaviorally-based prevention interventions is important to grantees and community planning groups for several reasons. First, many of the articles in the literature on intervention effectiveness include a description of the theory used to design the prevention intervention. In order to understand this literature, planners must be familiar with common theories. Second, while planning a comprehensive HIV prevention program, there may be unmet needs for which there are no proven interventions (e.g., for a particular population) reported in the literature. Therefore, planning groups will need to make recommendations about the types of interventions that may address these unmet needs. A basic foundation in behavior theory will be essential to planning groups who are faced with this task. As pointed out in Chapter 6, the extent to which an intervention is theory-based is one of the attributes community planning groups should use in prioritizing interventions. This appendix presents a brief description of some of the major theories from the behavioral and social science literature that have been used in HIV/AIDS prevention research.

## Theories of Behavior—A Primer

To develop and choose among interventions to change human behavior, it is useful to understand why people behave the way they do. Stated another way, the more we know about the factors underlying the performance or nonperformance of a behavior, the more successful we can be at designing an intervention that successfully influences that behavior. Research can be done to determine which of several theoretical factors predicts or explains a particular behavior in a particular population. Interventions can then be developed to influence these intervening factors and thus to facilitate the desired prevention behavior.

There are many different theories of human behavior and behavior change that have been used to understand, explain, and predict health behavior. Of these many theories of behavior, three have been most frequently used in the behavioral and social science research on the prevention of HIV infection: the Health Belief Model, the Theory of Reasoned Action, and Social Cognitive Learning Theory. In addition to these three major theoretical models, there is a Transtheoretical Model that focuses on Stages of Behavior Change. Good reviews of the specific dimensions of each theory are found in Leviton (1989; 1990) and Baranowski (1990). The following discussion presents basic principles for each of these theories, provides references for further more detailed reading and illustrates how the relevant factors might underly HIV prevention interventions.

## Health Belief Model

The Health Belief Model is essentially a health education approach to behavior and intervention design. The model has been used to explain and understand a wide variety of health behaviors, including prevention and screening behaviors like participation in cardiovascular screening, immunization and checkup programs as well as treatment behavior like smoking cessation and compliance with dialysis regimens (Janz and Becker, 1984; Kirscht and Joseph, 1989; Rosenstock, 1974). More recently, it has been applied to behaviors that place people at risk of

Note: This manuscript is authored by Richard Windsor, PhD, Susan E. Middlestadt, PhD, and David Holtgrave, PhD.

HIV infection (e.g., Becker, 1988; Kirscht and Joseph, 1989; Montgomery et al., 1989).

As the name implies, the Health Belief Model assumes that health behavior is a function of four key health beliefs: the perceived personal susceptibility or vulnerability to the negative health condition; the perceived severity of the condition; the perceived efficacy of the behavior in dealing with the condition; and, the barriers to the behavior. Together, these belief components produce a readiness to act. In addition, many proponents of the health belief model recognize that cues to action are necessary to initiate action once the readiness is above threshold and that a variety of personal and social characteristics such as age, sex, knowledge, and culture play a role in modifying the behavior if and when it occurs.

An HIV-prevention intervention designed, for example, to facilitate correct and consistent condom use based on the health belief model would try to influence these theoretical factors. The intervention might try to get individuals to realize that their behaviors place them at risk of HIV infection, thus increasing their perception that they are susceptible or vulnerable to HIV infection. Alternatively, it might focus on the severity factor, a person's belief that AIDS is a deadly disease, or the effectiveness factor, the belief that correct and consistent condom use will effectively prevent or reduce HIV infection. An intervention that encouraged people to carry condoms would be addressing a possible barrier to condom use. Messages in the mass media that reminded people to use condoms could be construed as providing cues to action. Ideally, the choice of the factor to address with an intervention would be made on the basis of behavioral research that identified that factor as an important determinant in the particular population of interest.

## Theory of Reasoned Action

The Theory of Reasoned Action, a social psychological approach to behavior, assumes that changing behavior is a matter of changing the cognitive structure underlying the behavior in question. The theory is a general theory of behavior that deals with the relations among beliefs, attitudes, intentions, and behavior (Ajzen and Fishbein, 1980; Fishbein and Ajzen, 1975) and has been used to understand behaviors from a variety of domains including health in general and HIV/AIDS in particular (Fishbein and Middlestadt, 1989; Fishbein et al., 1991).

In some respects, the theory is best seen as a series of four hypotheses. At the first level, a behavior is assumed to be primarily a function of a person's intention to perform that behavior. At the next level, the intention to perform the behavior is seen as a function of the weighted combination of two factors, a personal factor (the attitude toward the behavior) and a social factor (subjective norm). The attitude toward the behavior is the feeling of favorableness toward the behavior; the subjective norm is the perception that important others think that he or she should (or should not) perform the behavior. Underlying the attitude toward the behavior is an underlying cognitive structure of behavioral beliefs that performing the behavior will lead to certain outcomes and the evaluation of these outcomes. Underlying the subjective norm is an underlying cognitive structure of normative beliefs that particular individuals or groups think that one should or should not perform the behavior and the person's motivation to comply with each of these significant others.

An intervention to encourage correct and consistent condom use that is based on the Theory of Reasoned Action would address either the cognitive structure underlying the attitude toward the behavior or the subjective norm. For example, an intervention that convinced people that correct and consistent condom use effectively reduced risk of other sexually transmitted diseases would be addressing the behavioral belief factor underlying the attitude toward the behavior, facilitating a more favorable attitude, making the intention more positive and thus increasing the likelihood that the behavior will be performed. Note that, according to the Theory of Reasoned Action, beliefs about outcomes other than health outcomes might be important determinants. Thus, to deal with the behavioral belief that condom use might have lead to distrust in the relationship, an intervention might need to be developed to facilitate ways to introduce condoms among partners that strengthened rather than threatened the relationship. From a normative perspective, an intervention that reinforced the normative belief that peers expected the person to use condoms correctly and consistently would be addressing the cognitive structure underlying the subjective norm, making the person perceive more normative pressure, have a more positive intention, and thus be more likely to use a condom correctly and consistently. Again, ideally the choice of the particular factor to address would be based on empirical research in the target population of interest.

## Social Cognitive Learning Theory

The roots of Social Cognitive Learning Theory lie in the learning approaches to psychology as well as in clinical psychology applications to correct dysfunctional behaviors. Learning theory focuses on behavior and the antecedents and consequences of behavior in the environment. By contrast, Social Cognitive Learning Theory recognizes the important role of cognitive interpretations. That is, Social Cognitive Learning Theory (Bandura, 1977; 1986) is based on a triadic relationship among the person, behavior, and the environment through a process called "reciprocal determinism." In other words, whereas the environment largely determines or causes behavior, the person uses cognitive processes to interpret both the environment and his or her behavior, and also behaves in ways to change the environment and meet with more favorable behavior outcomes. This theory has been used effectively to explain and change a diverse set of health behaviors such as smoking cessation, weight reduction, increase in exercise and contraceptive practices, and recently AIDS prevention (Bandura, 1989; 1991).

According to Social Cognitive Learning Theory, two sets of cognitions are important in understanding and changing behavior: outcome expectations and self-efficacy. Outcome expectations include a person's interpretations of the consequences of performing the behavior. The person will perform the behavior to the extent that he/she believes it will pay off or will lead to positive consequences and avoid negative consequences. This aspect of Social Cognitive Learning Theory is very similar to the Theory of Reasoned Action. Self-efficacy is the person's belief in their capabilities and confidence in performing the behavior, their belief that they can choose to do it under difficult circumstances, and can persevere in the face of difficulties.

These self-efficacy cognitions represent a particularly important contribution of Social Cognitive Learning Theory. Just considering the HIV-prevention behavior of correct and consistent condom use, it is clear that skills at buying, correctly using, having available, and discussing and overcoming partner's resistance are vital. And, people must not only have these skills but must be confident in their abilities, they must have self-efficacy. Theoretically, a person with a strong sense of self-efficacy would be more likely to try a behavior, set a higher goal for how well or often the behavior is performed, persevere longer, use a variety of strategies, and try again when faced with temporary setbacks.

An intervention based on Social Cognitive Learning Theory might have people watch models successfully negotiating condom use with a partner in a variety of different circumstances. These materials could not only teach negotiation skills but could promote self-efficacy or confidence in abilities as well as demonstrate possible positive outcomes of effective negotiation.

## Common Factors Underlying the Three Behavioral Theories

Fortunately for the program planner attempting to set priorities among interventions based on sound behavioral and social scientific theory, there is a significant amount of overlap and consistency among these three major theories of behavior. In fact, based on a series of meetings among theorists representing each of these theories, a list of eight basic or common factors has been identified (Fishbein et al., 1993). These factors not only represent points of consensus among the theorists, but have been empirically shown to account for or explain most of the variation in any given behavior. These eight factors were summarized in a National Commission on AIDS 1993 report (National Commission on AIDS, 1993) and are shown in Table A-1.

## Transtheorectical Model

As implied by its name, the Transtheoretical (or Stages of Change) Model attempts to explain health behavior independent of specific theoretical factors. Instead, this model (Prochaska and DiClemente, 1986) proposes that behavior change occurs in a series of stages. This model assumes that individuals start with no intention to change, form weak intentions, strengthen these intentions, try the behavior inconsistently at first, and then finally adopt the new behavior as a routine part of their lives. These stages are described in Table A-2.

Movement through the stages will vary greatly from population to population and from individual to individual. Some people may remain in the contemplative stage for months or years; others cycle back and forth between stages. Once a person initiates or adopts a behavior, that person is vulnerable to relapse. Effective interventions first determine where the population is on this continuum of behavior change and move them to the subsequent, more advanced stage. Baseline and follow-up assessments of the percentage

of population of interest will help the planning group to plan interventions and assess progress and movement through the stages.

Public health interventions have often been developed for populations in the preparation stage by promoting an immediate behavior change, like consistent condom use. However, according to this theory, when the majority of the target population is in the pre-contemplation stage, this type of intervention will only be partly effective in promoting behavior change. To be effective, intervention methods and messages must be targeted to the specific needs and stage of a group. The various factors from the three major theories, the Health Belief Model, the Theory of Reasoned Action, and Social Cognitive Learning Theory, can help move persons from stage to stage in the Transtheoretical Model. For example, to motivate individuals at the pre-contemplation stage to form intentions, an intervention might first alert them of the potential danger of not changing by creating a perception of risk. For individuals at the preparation stage who have formed an intention to behavior, an intervention might try to increase the self-efficacy for the behavior. For further information on how this might be done, see Baranowski (1990) and O'Reilly and Higgins (1991).

## The Importance of Sound Scientific Theory for Designing, Evaluating, and Selecting Among HIV Prevention Interventions

There are a number of advantages to understanding and using sound behavior and social science theory. Research to identify the factors associated with the behaviors that place people at increased risk of infection and thus to identify behavioral determinants to be addressed by intervention is more effective and interpretable if it is guided by sound theory. The theories serve to outline important behavioral factors, to indicate ways of measuring these factors and to facilitate the communication of the results. Put most simply, evaluation research that identifies not only that behavior changed but which intervening factor contributed to that change allows the planner to understand why the intervention worked, thus increasing the likelihood of successfully replicating it.

No one theoretical model has been found to predict human behavior with complete success. However, even imperfect theories can provide useful guidance in designing, evaluating and choosing among HIV prevention interventions. Important opportunities to translate the components of behavioral theories into public health practice remain. For further information on this topic, see Valdiserri et al. (1992).

## Table A-1: Common Theoretical Factors

| The Population at Risk Must: | Factor |
|---|---|
| 1. Believe the advantages of performing the behavior (benefits) exceed the disadvantages | Expected Outcomes (attitude) |
| 2. Have formed a strong positive intention or be committed to perform a behavior | Intention |
| 3. Possess the skills to perform a behavior | Skills |
| 4. Believe that they can perform a behavior | Self-Efficacy |
| 5. Believe that the performance of a behavior will more likely produce a positive than a negative emotional response | Emotion |
| 6. Believe that the performance of a behavior is consistent with their self-image | Self-Standards |
| 7. Perceive greater social pressure to perform a behavior than not to perform it | Perceived social norms |
| 8. Experience fewer environmental constraints to perform a behavior than not to perform it | Barriers |

Adapted from National Commission on AIDS, 1993

## Table A-2: Stages in the Transtheoretical Model

| | Stage Description |
|---|---|
| 1. Pre-contemplation | People in this stage have no intention to change behavior in the foreseeable future, are unaware of the risk, or deny the consequences of risk behavior. |
| 2. Contemplation | People are aware that a problem exists, are seriously thinking about overcoming it, but have not yet made a commitment to take action. |
| 3. Preparation | People intend to take action in the near future and may have taken some inconsistent action in the recent past. |
| 4. Action | People modify their behavior, experiences, or environment to overcome their problems; the behavior change is relatively recent. |
| 5. Maintenance | People work to prevent relapse and maintain the behavior change over a "long" period of time. |

Adapted from Prochaska and DiClemente, 1986

## Logic Model Training Curriculum, Maryland

**Logic Model Training**
**Developed and Delivered by: The Evaluation Division**
**February 29, 2000**
**8:45 am-12:00pm**

**Goal:** To build the capacity of HIV prevention program monitors and planners to develop and utilize logic models to support intervention planning, design, monitoring and evaluation requirements.

**Objectives:**

1. To define logic model terminology -inputs, activities, outputs, outcomes and target population.
2. To provide opportunities to categorize statements using logic model terminology.
3. To demonstrate how a logic model is developed for a prototype HIV prevention program.
4. To provide opportunities to practice developing logic models for real HIV prevention interventions.
5. To provide opportunities to present logic models for real prevention programs to the full group.
6. To describe the uses and benefits of logic models.

**Agenda**

| | |
|---|---|
| 8:45-9:00 | Bagels and Coffee |
| 9:00-9:10 | Welcome<br>Workshop purpose (OH1 and OH2) |
| 9:10-9:20 | Brainstorm all the things that prevention program monitors and planners count (recorder writes items in four unlabeled columns – corresponding to inputs, activities, outputs and outcomes) |
| 9:20-9:35 | Using brainstorm list above, define logic model terminology – OH3 and OH4 |
| 9:35-9:55 | Categorization of Activity Statements OH5 and OH6 |
| 9:55-10:25 | Demonstration: Constructing a Logic Model OH7 and OH8 |
| 10:25-10:35 | Break |
| 10:35-11:15 | Small Groups: Logic Model Exercises |
| 11:15-11:45 | Small Group Presentations with Large Group Feedback |
| 11:45-12:00 | Uses and Benefits of Logic Models – OH9<br>Closure and Workshop Evaluation |

**Logic Model Training Annotated Agenda**
**Developed and Delivered by: The Evaluation Division**
**February 29, 2000, 8:45 am-12:00pm**

**Annotated Agenda**

| | |
|---|---|
| 8:45-9:00 | Bagels and Coffee |
| 9:00-9:10 | Welcome – inspiration for the workshop; use of logic models is growing<br>Workshop goal and objectives (OH1 and 2) |
| 9:10-9:20 | Brainstorm all the things that prevention program monitors and planners count (recorder writes items in four unlabeled columns – corresponding to inputs, activities, outputs and outcomes) |
| 9:20-9:35 | Identify column titles. Summarize where most of the things we count are. What are the implications of this in a new funding environment. Using brainstorm list above, define logic model terminology and show what a logic model looks like. (OH3 and OH4) |
| 9:35-9:55 | Activity Statement Identification Handout – Trainees complete handout individually or in pairs. Work through and discuss answers as a large group– (OH 5 and 6) |
| 9:55-10:25 | Demonstration of how a logic model is constructed – Bob – OH7 and OH8 |
| 10:25-10:35 | Break |
| 10:35-11:15 | Small Group Logic Model Exercises –<br>**3 min** -Distribute intervention plans. Select a person to present each small group's logic model to the large group<br>**10 min** – have the group members cull out inputs, activities, outputs, outcomes from case materials and jot them down independently on paper<br>**10 min** – synthesize the input, activity, output and outcome statements from individual group members<br>**17 min** – analyze the logic of the model – does anything appear to be missing? Unrealistic? Out of order? Not scientifically sound? Not culturally sensitive? Make adjustments in the model to make it "logical", "realistic", scientifically sound, culturally sensitive. (Note: The groups probably will not cull every item from the cases in such short time…this isn't important. We want to get them to the point of analyzing the model) |
| 11:15-11:45 | Small Group Presentations with Large Group Feedback |
| 11:45-12:00 | Uses and Benefits of Logic Models – OH 9<br>Closure and Workshop Evaluation |

**Materials**

Overheads – OH 1: Training Goal
OH 2: Workshop Objectives
OH 3: Logic Model Terms and Definitions
OH 4: Logic Model Sequence
OH 5: Categorization of Activity Statements
OH 6: Logic Model for Activity Statements
OH 7: Large Group Demonstration Logic Model-Part 1
OH 8: Large Group Demonstration Logic Model-Part 2
OH 9: Uses and Benefits of Logic Models
Blank Transparencies that Small Groups may Use to Make Overheads of their Logic Models

4 Transparency Pens

Handouts - copies of agenda and selected overheads (30 copies)
- Case studies –copies for each small group (8 copies or each)

FlipCharts, Markers, Tape and FlipChart paper

Evaluation Forms (30 copies)

# TRAINING GOAL

To build the capacity of HIV prevention program monitors and planners to develop and utilize logic models to support intervention planning, design, monitoring and evaluation requirements.

# TRAINING OBJECTIVES

1. To define logic model terminology -inputs, activities, outputs, outcomes and target population.

2. To provide opportunities to categorize statements using logic model terminology.

3. To demonstrate how a logic model is developed for a prototype HIV prevention program.

4. To provide opportunities to practice developing logic models for real HIV prevention interventions.

5. To provide opportunities to present logic models for real prevention programs to the full group.

6. To describe the uses and benefits of logic models.

# Logic Model Definitions

**Input:**

A resource dedicated to or consumed in a program, project or intervention.

**Activity:**

Services the program provides to meet its objectives. What the program does with its inputs – how it goes about transforming them into products.

**Output:**

The direct products of program activities and operations.

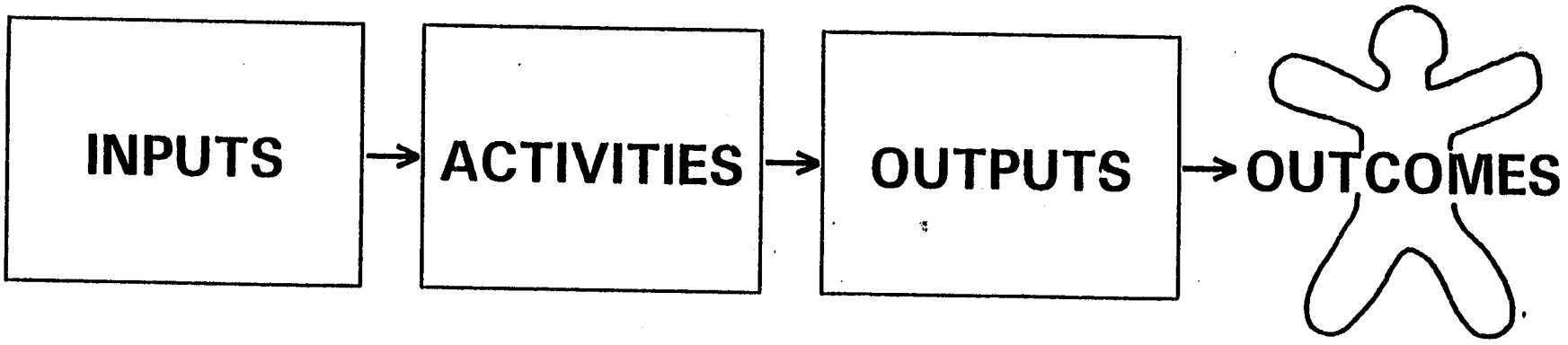
**Outcome:**

The benefits to participants during or after participating in the program.

**Target Population:**

The people your program aims to reach – often described according to age, gender, race/ethnicity and/or risk factors.

# Program Outcome Model




**Resources**

- ✓ money
- ✓ staff
- ✓ volunteers
- ✓ equipment & supplies

**Constraints**

- ✓ laws
- ✓ regulations

**Services**

- ✓ training
- ✓ education
- ✓ counseling
- ✓ mentoring
- ✓ internships

**Products**

- ✓ classes taught
- ✓ counseling sessions conducted
- ✓ educational materials distributed
- ✓ hours of service delivered
- ✓ participants served

**Benefits for People**

- ✓ new knowledge
- ✓ increased skills
- ✓ changed attitudes or values
  ↓
- ✓ modified behavior
  ↓
- ✓ improved condition
- ✓ altered status

## Activity Statements

Label the Following Statements with the Appropriate Letter:
**I** = Input
**A** = Activity
**OP** = Output
**OC** = Outcome
**T** = Target Population

_____ Middle School (MS) peer leaders engage their peers at school in 3-5 minute discussions about sexual risk reduction

_____ Sexually-active MS youth in neighborhoods with high HIV incidence

_____ "Be A Responsible Teen" curriculum

_____ MS youth engaged by peer leaders show an increased personal perception of risk

_____ 200 MS youth were engaged by peer leaders

_____ Condoms and brochures

_____ MS youth that never used condoms before use them when having casual sex

_____ Incentives

_____ 1000 condoms and 2000 brochures were distributed by peer leaders

_____ 22 youth engaged by peer leaders enroll to become new peer leaders

_____ 43 youth were referred to CTS in 1$^{st}$ quarter of the fiscal year

_____ A refresher course in HIV knowledge and communication strategies is held for peer leaders

_____ The target Middle School forbids distribution of condoms on school property

ANSWER KEY

## Activity Statements

Label the Following Statements with the Appropriate Letter:
**I** = Input
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T Sexually-active MS youth in neighborhoods with high HIV incidence

I "Be A Responsible Teen" curriculum

OC MS youth engaged by peer leaders show an increased personal perception of risk

OP 200 MS youth were engaged by peer leaders

I Condoms and brochures

OC MS youth that never used condoms before use them when having casual sex

I Incentives

OP 1000 condoms and 2000 brochures were distributed by peer leaders

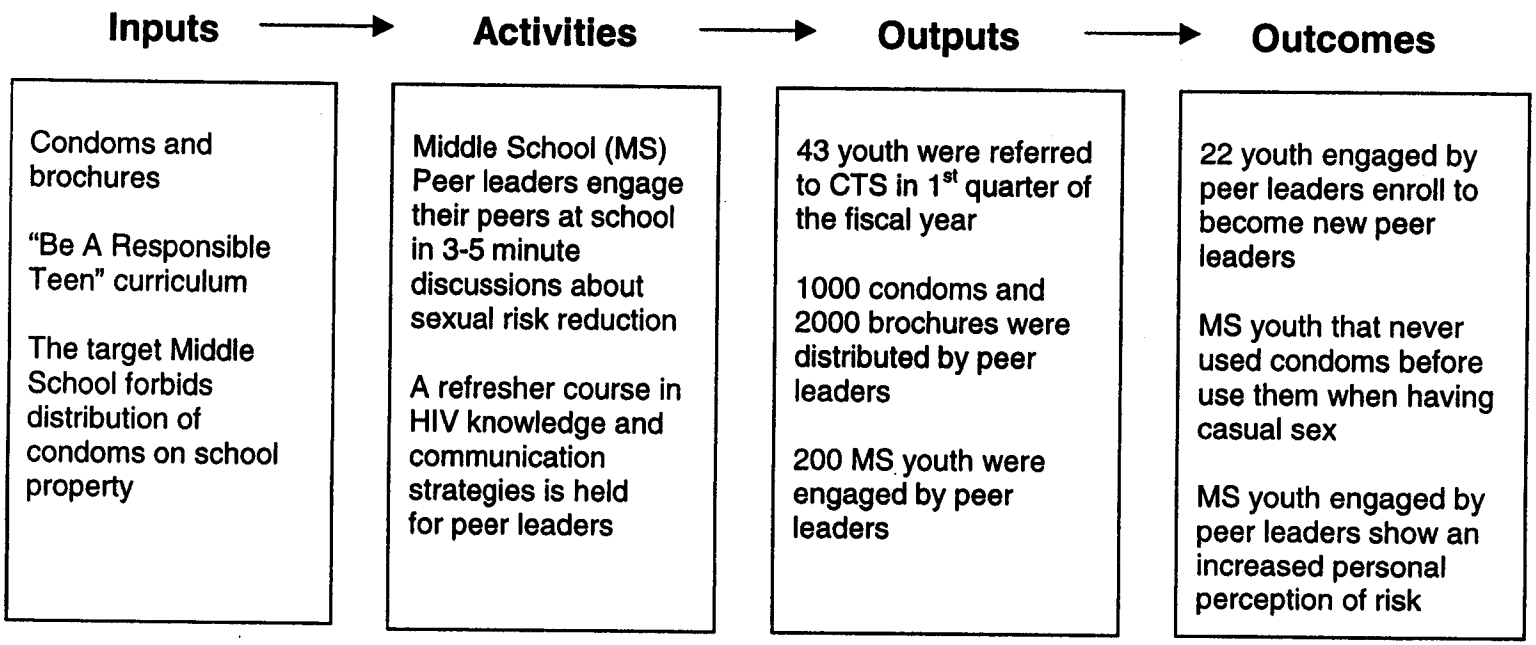
OC 22 youth engaged by peer leaders enroll to become new peer leaders

OP 43 youth were referred to CTS in 1st quarter of the fiscal year

A A refresher course in HIV knowledge and communication strategies is held for peer leaders

I The target Middle School forbids distribution of condoms on school property

# Activity Statements in Logical Order




**Target Population**: Sexually-active MS youth in neighborhoods with high HIV incidence

# African-American MSM Outreach Program - Logic Model

**Key Influencer Training**

| INPUTS | ACTIVITIES | OUTPUTS | OUTCOMES |
|---|---|---|---|
| Key influencer recruitment | Key influencer training sessions | # of key influencers recruited | Key influencers qualified to contact/train others in prevention |
| Meeting space for training | Training session 1 topics: HIV/AIDS facts Personalization of risk Communication skills | # of key influencer training sessions | Education/role modeling by key influencers to others |
| Vendor training staff | Training session 2 topics: Etc. | # of key influencers fully trained | Increased knowledge of HIV/AIDS, transmission, and prevention |
| Training curriculum: Empowerment & Skills Building | | # of trainees attending session 1 | Increased perception of severity of HIV and susceptibility to infection |
| | | | Increased skills and self-efficacy for educating others about HIV and risk reduction |

# African-American MSM Outreach Program - Logic Model
12/99

**Outreach**

| INPUTS | ACTIVITIES | OUTPUTS | OUTCOMES |
|---|---|---|---|
| Trained key influencers | One-on-one outreach contacts | # of outreach contacts made | Increased knowledge of HIV/AIDS, transmission, and prevention |
| Permission for outreach activities from MSM-oriented businesses | Distribution of HE/RR literature | # of pieces of HE/RR literature distributed | Increased perception of personal risk |
| | Distribution of condoms/barriers | # of condoms/ barriers distributed | Increased awareness of CTS services as confidential/anonymous |
| | Invitation of contacts to HE/RR small group sessions | # of contacts recruited to HE/RR sessions | Increased condom/barrier use |

# Uses and Benefits of Logic Models

- "Helps to Get People on the Same Page" About the Programs Goals and Strategies
- Helps to Identify Gaps in the Program
- Helps to Show When Resources are not Sufficient to Meet Outcome Objectives
- Highlights Things You Might Want to Measure in an Evaluation
- Good Communication Tool for Funders and/or Grantees
- Shows Internal Logical Consistency of Plan
- Maps Out Program Paper Flow

## Project 1: HIV Outreach to Latin Americans (HOLA)

**Target Population:** Hispanic/Latino adults with low level of formal education & at high-risk for HIV infection.

**Program Goal:** To reduce high-risk behaviors related to the transmission of HIV and other STDs in heterosexual Hispanic/Latino adults.

### Outcome Objectives:

Trained Key Influencers will demonstrate increases in:

* Knowledge of HIV/STD transmission and prevention;
* Knowledge of culturally & linguistically competent resources accessible to Latinos;
* Perceived risk for and severity of HIV/STD infection;
* Positive attitudes toward using condoms as an HIV/STD risk reduction device;
* Perception that HIV and STD Counseling and Testing services are accessible, confidential, anonymous, and culturally and linguistically competent;
* Skills and self-efficacy in educating other Latinos/Hispanics about HIV/STD;
* Intentions to conduct HIV/STD prevention outreach among Latinos/Hispanics;
* Skills and self-efficacy in demonstrating how to correctly use condoms and clean needles.

Recipients of encounters with Key Influencers will show increases in:

* Knowledge of HIV/STD transmission and prevention strategies;
* Perceived risk for and severity of HIV/STD infection;
* Knowledge of the prevalence of HIV/STD in the Latino/Hispanic community;
* Knowledge of culturally and linguistically competent, anonymous, keep confidential HIV and STD services accessible to Latinos/Hispanics.

### Process Objectives:

* Establish & maintain an HIV/AIDS Advisory Committee (AC) consisting of HIV/AIDS professionals and community representatives from the target population to provide advice and assistance with project activities. The AC will meet at least once every two months and the first meeting will be conducted within 6 weeks of the contract execution date.

By the end of the first quarter, the Grantee shall:

* Recruit and provide a minimum of 10 hours of culturally and linguistically appropriate HIV and STD prevention related training to a minimum of eight (8) not previously trained Hispanic/Latino adults who will become Key Influencers in their community.

During the second, third and fourth quarters, the Grantee shall:

* Insure that trained Key Influencers engage at least 5 of their peers monthly in HIV & STD educational outreach activities for a total reach of 360 Hispanic/Latinos from target area.
* Provide regular follow-up training & assistance to Key Influencers previously trained & currently providing service.
* Conduct 2 small group, multi-session interventions with 10-15 participants per group. Key Influencers will partner with vendor in planning, recruiting & implementing interventions.
* Insure that Key Influencers have access to culturally and linguistically appropriate prevention materials to distribute to reinforce HIV prevention activities.
* Insure that Key Influencers refer high-risk individuals for bilingual HIV Counseling and Testing and other health and human services as indicated.

## Project 2: African American High-risk Youth

**Target Population:** African American youth who engage in high-risk behaviors and/or who live in high HIV/STD prevalence communities.

**Program Goal:** To reduce high-risk behaviors related to the transmission of HIV and other infectious diseases in African American youth.

**Outcome Objectives:**
Youth participants will demonstrate increases in:

* Knowledge of HIV/STD transmission and risk reduction strategies;
* Perceived risk for and severity of HIV/STD infection;
* Self-efficacy and intentions to reduce high-risk behaviors;
* Positive attitudes toward condom use;
* Mechanical skill in effective condom use;
* Skills to counsel others regarding risk reduction and behavior modification;
* Skills in assertive communication, negotiation and refusal;
* Knowledge of youth-friendly, accessible HIV and other health and human service programs, services and resources.

**Process Objectives:**
By the end of the first quarter, the Grantee shall:

* Recruit and train facilitator(s) (.4 FTE) to use the Be Proud Be Responsible curriculum, the BART curriculum, or another curriculum approved by the Department to conduct multi-session, group level interventions with high-risk youth in community settings.

* Identify community locations from which to recruit high-risk youth for the multi-session intervention. For example, youth can be recruited through schools, Boys & Girls Clubs, counseling centers, comprehensive health centers, church groups, runaway shelters, group homes, and other social clubs.

* During the second, third and fourth quarters, facilitators will conduct a minimum of 128 hours of small group, multi-session interventions using the curriculum in which the Facilitators were trained. This total session time may reflect 8 groups completing a 16-hour intervention, 16 groups completing an 8-hour intervention or any variation of this concept. The number of youth in each group may range from 6-12.

* Refer participants to HIV Counseling and Testing services and/or other health or human services as indicated.

* Distribute educational materials, condoms, and other devices to participants with appropriate written parental consent, if required.

* Administer all monthly reporting materials and evaluation instruments as determined by the Department.

## Project 3: African American High-risk Women

**Target Population:** African American women who engage in behaviors that put them at risk for becoming HIV infected.

**Program Goal:** To reduce high-risk behaviors related to the transmission of HIV in African American women.

**Outcome Objectives:**
Program Participants will demonstrate:

* Increased knowledge of HIV/STD transmission and risk-reduction strategies;
* Increased assertiveness, communication and negotiation skills;
* Increased attitudes and norms supportive of consistent condom use;
* Positive movement along the following stages of behavior change (pre-contemplation ( contemplation ( preparation ( action ( maintenance);
* Increased skills and self-efficacy to correctly use condoms and clean needles.

**Process Objectives:**
By the end of the first quarter, the Grantee shall,

* Recruit Outreach Specialist(s) (.6 FTE), who are experienced in leading groups and ideally should match the participants on the basis of gender and ethnicity.
* Ensure that Outreach Specialist(s) attend training in HIV/AIDS/STD education and risk reduction strategies using the RAPP curriculum as provided by the Department.

During the second quarter, the Outreach Specialist(s) will:

* Conduct stage based outreach to the target population;
* Network in the community to raise awareness about the program, establish drop off sites for educational materials and identify community locations from which to recruit Peer Educators;
* Recruit at least 15 Peer Educators who are experienced in outreach and ideally should match the target population on the basis of gender and ethnicity.
* Train the Peer Educators in HIV/AIDS/STD education and risk reduction strategies using the RAPP curriculum.

During the third and fourth quarters, Outreach Specialist(s) will:

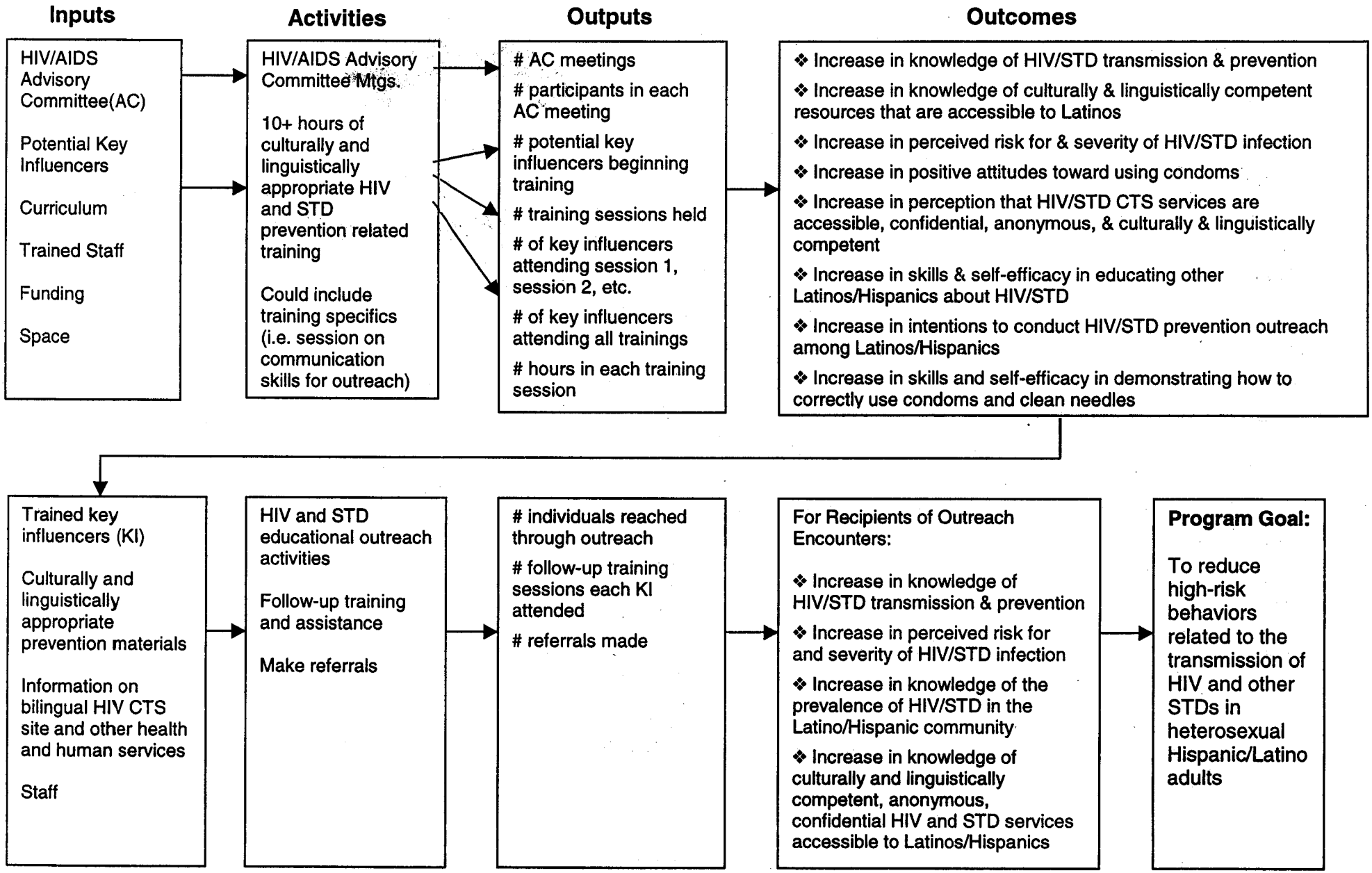
* Provide mentoring and additional training to Peer Educators as needed;
* Conduct a minimum of 15 two-hour (minimum time) small group Home Health parties/Educational Sessions with 6-12 participants in each intervention group. Settings for these sessions may include homes, community-based organizations, substance abuse treatment facilities, domestic violence shelters, detention centers, etc.

During the third and fourth quarters, Peer Educators will:

* Conduct stage based outreach to the target population;
* Distribute role model stories to drop off sites;
* Recruit hosts/organizations for the small group Home Health parties/Educational Sessions conducted by the Outreach Specialist(s).
* Work with Dept. to develop targets for intensive, high quality outreach encounters.
* Refer participants to HIV Counseling and Testing services and other health and human services as indicated.

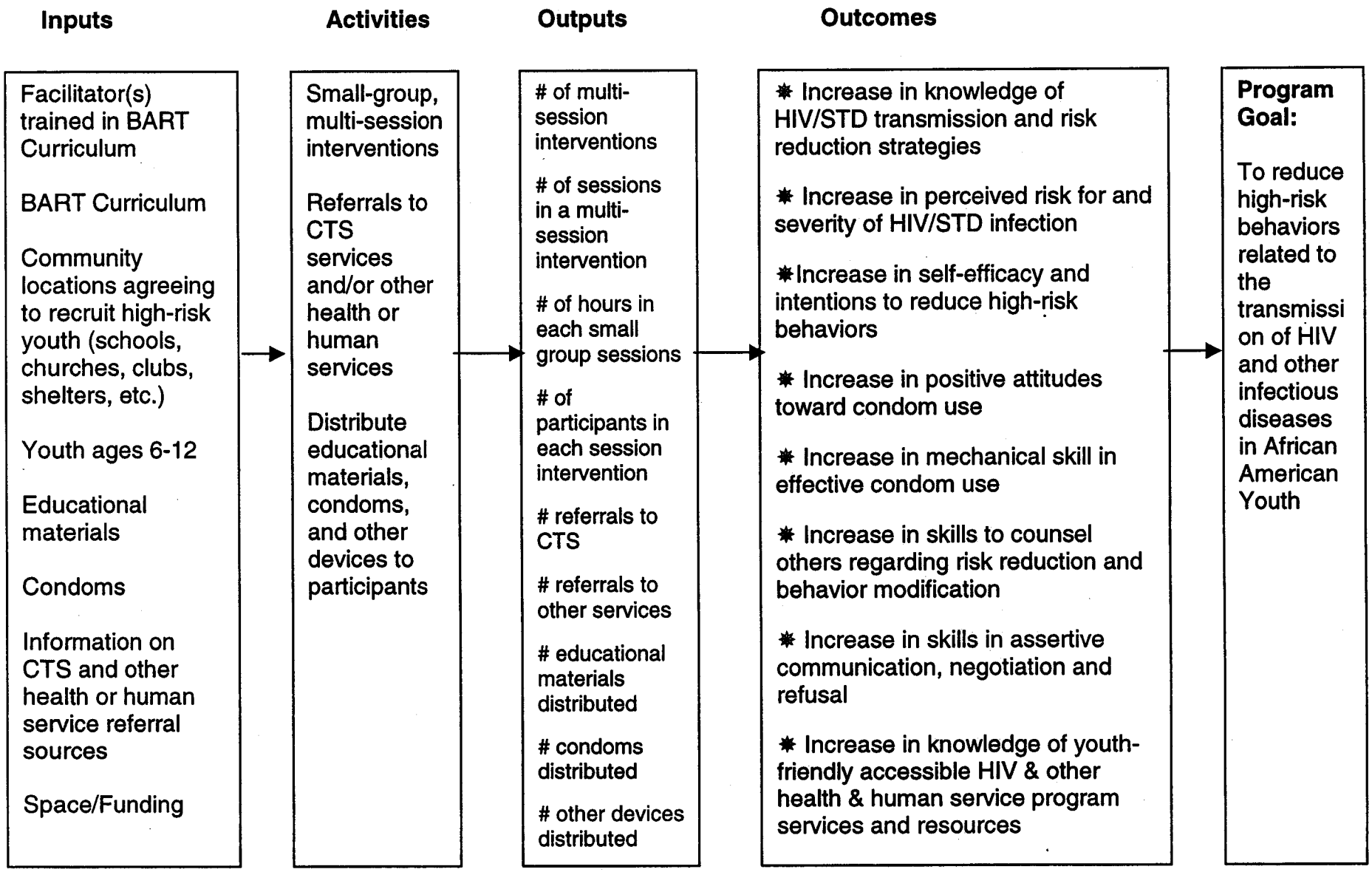
## HIV Outreach to Latin Americans (HOLA Peer Educator Model)

**Target Population:** Hispanic/Latino(a) adults with low levels of formal education and at high-risk for HIV infection.



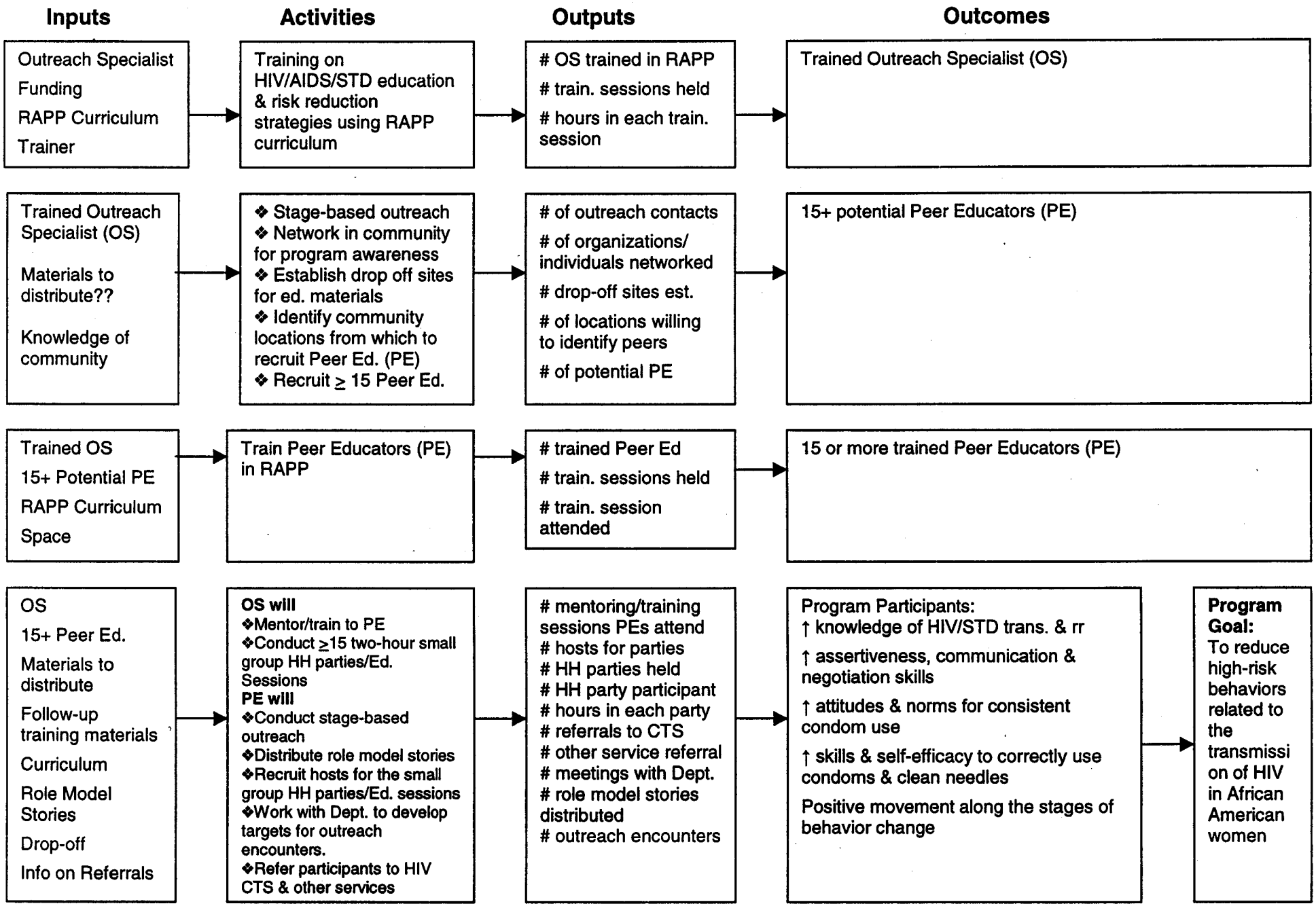
## African American High-risk Youth

**Target Population:** African American youth who engage in high-risk behaviors and/or who live in high HIV/STD prevalence communities.



## African American High-risk Women

**Target Population:** African American women who engage in behaviors that put them at risk for becoming HIV infected



## Intervention Standards, Colorado

# Chapter 10

## Health Education/risk Reduction Interventions (Group, Individual, and Population Level)

### Group Level Interventions

There are two subcategories of Group Level Intervention: Group Risk Reduction Education and Comprehensive Health Programs for Youth

**Group Risk Reduction Education**

Group Risk Reduction Education (GRRE) provides small groups of individuals at high risk of acquiring or transmitting HIV infection with: educational interventions that promote and reinforce safer behaviors; interpersonal skills training and support in negotiating and maintaining safer sexual and needle-sharing behaviors; emphasis on the relationship between substance use and risky behaviors; educational materials; and referrals to appropriate services.

Goal of the Intervention

GRRE seeks to lower risk behavior among small groups of individuals who are at high risk of acquiring or transmitting HIV infection.

Target Population

Ideally, GRRE occurs in a small-group setting with five to 20 individuals who are at high risk of acquiring or transmitting HIV infection

Cultural competence/proficiency

All providers of GRRE should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment developed in conjunction with the CWT Cultural Competence Committee. See chapter 2 for further information on competence/proficiency regarding culture, disability, and other diversity.

Where Delivered

The locations are convenient and accessible to members of the target group (as determined by formative evaluation).

When Delivered

The meeting times are convenient to members of the target group as determined by formative evaluation.

How Much

Whenever possible, groups should consist of multiple sessions.

Content and Methods Employed

Educational interventions include: the promotion and reinforcement of safer behaviors; interpersonal skills training and support in negotiating and maintaining safer sexual and needle-sharing behaviors; emphasis on the relationship between substance use and risky behaviors; educational materials; and referrals to appropriate services.

Content and methods of delivery may include group discussion, role plays, skill building exercises, games, demonstrations, and appropriate referrals (see #8 under "General Characteristics of Successful HIV Prevention Programs").

The educational methods, content, and length of presentations are appropriate and acceptable to the target audience (as determined through formative evaluation).

Qualifications of People To Do This Work

Providers of GRRE should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

The educators may be peers or professionals who are competent in regard to culture and other diversity and able to present the materials in an understandable and non-judgmental manner.

Continuing Education/Ongoing Training Requirement

Providers of GRRE must receive at least 8 hours of updated HIV prevention training per year.

Consent/Confidentiality Considerations

Programs must insure confidentiality of program participants. See confidentiality provisions of the Code of Ethics in chapter 4.

Quality Assurance

All providers will provide a system for client feedback; see Chapter 8

Supervisors and project officers should assure the quality of the group instruction and facilitation through periodic observations. Regular meetings should be held among facilitators/instructors and supervisors to discuss relevant issues (successes, problems, barriers, etc.).

Evaluation

Formative, process, and outcome evaluation should be implemented and results should be utilized in the updating of services.

Formative Evaluation Standards:

1. All interventions are expected to utilize formative evaluation methods when developing and revising their interventions.
2. Formative evaluation methods used in intervention development and revision should be listed and briefly described in intervention plans and applicable progress reports submitted to CDPHE.

   Comments: Formative evaluation methods are used in the planning and development phase of an intervention, to learn more about how best to access and influence community members, as well as to "test-out" an intervention, its components, or materials, before full implementation or revision. Examples of formative evaluation methods include interviews and focus groups with members of target populations to better understand risk behaviors and how best to help them to lower risk, pilot tests (rehearsals of workshop activities like role plays, mock interviews, etc.), pre-testing of materials (letting people review drafts of scripts, pamphlets, overheads, or other intervention materials before finalizing them), and focus groups to discuss the best ways to recruit participants and present information.

Process Evaluation Standards

Over the next five years, CDC intends for grantees to have a data collection system in place that enables the collection of all the information presented below. CDPHE recognizes that full implementation will take time and asks that providers make efforts to increase their own capacities to collect these data. For now, providers will be asked to provide as much of this information as possible, moving toward the collection of all information over the next five years.

On CDPHE supplied forms, providers will be asked to provide the following types of information:

b. Agency Identification/Agency Type (CBO, Academic, State/Local Health Dept., etc.)
c. Reporting Month/Year
d. Type of Activity (Outreach, Workshop, etc.)
e. Primary and Secondary Target Populations
f. Setting of Intervention (Street, School, Clinic, etc.)
g. Target Population Demographics
h. Target Population Risk Behaviors
i. Number of Intervention Episodes/Sessions
j. Number of prevention materials distributed by type
k. Numbers of referrals made by type
l. Number of referrals followed-up on (may not be required until 2001)
m. Number of staff implementing intervention (at time of reporting)
n. Budget
o. Expenditures

Outcome Monitoring Standards:

By January 2001, all HE/RR and individual and group level interventions will begin outcome monitoring.

Outcomes measured should reflect specific outcome objectives stated in the intervention plan and when applicable, address the Comprehensive Plan's Indicators.

Outcome Evaluation Standards

See chapter 3 concerning the need for adc onal clarification and funding before this type of evaluation will be conducted in Colorado.

By May 2003, the outcomes of at least one HE/RR individual or group level intervention implemented during the 5-year period will be evaluated and compared to outcomes in a comparison group. Evaluation results will be reported in the 2004 HIV Prevention grant application.

Penalties for Violating Standards

1. Provider staff will meet with the CDPHE to develop a quality improvement action plan for improving performance in specified areas.
2. The provider will be given a probationary period to comply and meet the standard.
3. The provider will be reevaluated by the end of the probationary period.
4. Failure to meet and comply with the standard may result in contract termination.

Other

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature.

Providers of GRRE should have protocols in regard to the safety of clients, volunteers, and staff.

## Data Collection Form, Wisconsin

# Instructions for the Behavioral Risk Assessment Tool (BRAT)

## Introduction

The attached Behavioral Risk Assessment Tool (BRAT) was developed by the Wisconsin HIV Prevention Evaluation Work Group with additional input from evaluation experts from the Center for AIDS Intervention Research (CAIR) and the Centers for Disease Control and Prevention (CDC). The BRAT was most recently revised 12/00.

The BRAT is a two-page form that collects information regarding HIV prevention clients':

- Demographic characteristics (race/ethnicity, age, gender)..
- Sexual practices (including condom use and number and gender of partners);
- Injection and other drug use (including needle-sharing practices);
- HIV-related risk factors (e.g. trading sex for drugs, sex under the influence of alcohol or drugs, homelessness, incarceration); and
- HIV antibody testing history.

## Purpose

The BRAT serves two primary purposes:

1. **To improve agencies' capacity to assess sexual and needle sharing behaviors of their clients.** This information can be used both to help staff counsel clients about their individual risks and to assess changes in clients' behaviors during and after their participation in HIV prevention activities.
2. **To assist agencies in more effectively targeting HIV prevention services to persons at highest risk for HIV infection.** This goal seeks to expand agencies' general knowledge of their target populations. It also seeks to maximize limited HIV prevention resources by helping agencies prioritize those clients most in need of services.

## Use of the BRAT by Intervention Type

Agencies are strongly encouraged to use the BRAT as described below for the following interventions.

- For **Prevention Case Management (PCM)**, the BRAT should be used at or near intake, after 2 months, 6 months, and if possible, at 3-month intervals after that, as well as at discharge and 3 months post discharge.
- For **Individual-level** interventions, the BRAT should be used at or near intake and at discharge, and if possible, 3 months after discharge.
- For **Group-level** interventions, the BRAT should be used at or near intake and at the end of the group, and if possible, 3 months after discharge.
- For **Outreach**, the BRAT should be used periodically. In this case, it is expected that the BRAT would be administered on a one-time basis, so no client code is needed.
- For **Counseling and Testing, HC/PI, Capacity-building** interventions, the BRAT can be used at the discretion of the agency.
- A client code must be used to track multiple assessments of the same client as is the case for Individual-level, Group-level and PCM interventions.

Agencies with Individual, Group, PCM, and Outreach are expected to use the BRAT in 2001 and to submit the data quarterly using the database in MS Access.

## Methods of Administering the Form

There are four methods by which the tool can be administered:

1. An HIV Prevention Specialist can interview a client on a one-on-one basis. The Specialist asks the questions and records the client's responses ("Completed by Staff" in the shaded box at the bottom of the page).

2. An HIV Prevention Specialist can hand out the tool in a small group and walk through it verbally. Clients write the responses by themselves but can ask questions. ("Completed by Client – with instruction in a group").
3. The same procedure can be done with a client individually. ("Completed by Client – with individual instruction").
4. An HIV Prevention Specialist can hand the form to a client and ask him or her to complete it on their own. ("Completed by Client").

The first method is the preferred one because it avoids confusion and reading difficulties that may prevent the client from completing the form correctly. However, we recognize that the other methods may be more practical at times. In any case, be sure to complete the right-hand column of the shaded box on page 2, so it is clear how the form was completed.

**Instructions on the form**

Please complete all items. If the answer to an item is "no", please check "no" rather than leaving the item blank.

If a client is incarcerated, instruct him or her to complete the form for the period immediately prior to incarceration rather than for the current period.

**BRAT database in Microsoft Access**

An electronic database in Microsoft Access enables grantees to enter the data and generate their own reports. Data will also be shipped to the AIDS/HIV Program on a quarterly basis, so we can provide summary reports to the Wisconsin HIV Prevention Community Planning Council and CDC. For technical reasons, this database cannot be web-based. Training will be provided in late January 2001 and instructions are provided on the database.

**Contact**

If you have questions, please contact:

Mari Gasiorowicz
AIDS/HIV Program
HIV Prevention Evaluation
Phone: 608/267-9489
Fax: 608/266-2906
Email: gasioma@dhfs.state.wi.us

# WISCONSIN HIV BEHAVIORAL RISK ASSESSMENT TOOL

Please answer each question below by placing an X in the appropriate space. Do not write your name on this form.
If you are incarcerated (jail, prison, secured detention, etc.), complete the form for the time prior to being incarcerated.

**Race/ethnicity**
Mark your primary race/ethnicity first. If you identify with more than one, mark a secondary choice.

| | Primary | Secondary |
|---|---|---|
| African American/Black | ☐ | ☐ |
| American Indian | ☐ | ☐ |
| Asian/Pacific Islander | ☐ | ☐ |
| Hispanic/Latino/Latina | ☐ | ☐ |
| White | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

**Gender** ☐ Male ☐ Female ☐ Transgender

**Date of birth** ____/____/____ month/ date / year

| **In the last 3 months, have you...** | No | Yes | Not Sure |
|---|---|---|---|
| Been homeless? | ☐ | ☐ | |
| Been in alcohol or drug treatment? | ☐ | ☐ | |
| Had sex while high on drugs or alcohol? | ☐ | ☐ | |
| Had sex to get money, drugs, shelter, etc? | ☐ | ☐ | |
| Paid for sex with money or drugs? | ☐ | ☐ | |
| Had sex with a person who injects drugs? | ☐ | ☐ | ☐ |
| Had sex with a man who has sex with men? | ☐ | ☐ | ☐ |
| Been diagnosed with Hepatitis C? | ☐ | ☐ | ☐ |
| Been diagnosed with a sexually transmitted disease (e.g. Syphilis, Chlamydia, Gonorrhea, Hepatitis B?) | ☐ | ☐ | ☐ |
| Been in the correctional system? (Probation, parole, secured detention, juvenile corrections etc.) | ☐ | ☐ | |

| **Have you...** | No | Yes | Not Sure |
|---|---|---|---|
| Ever injected drugs | ☐ | ☐ | |
| Ever been in alcohol or drug treatment? | ☐ | ☐ | |
| Ever had sex against your will? | ☐ | ☐ | |
| Ever had sex with other men (men only) | ☐ | ☐ | |
| Are you pregnant now? (women only) | ☐ | ☐ | ☐ |

**In the past 3 months, have you had vaginal, oral, or anal sex?** No ☐ Yes ☐

| **If yes, with a...** | No | Yes | |
|---|---|---|---|
| Man? | ☐ | ☐ | How many men? ____ |
| Woman? | ☐ | ☐ | How many women? ____ |
| Transgender? | ☐ | ☐ | How many transgender? ____ |

**In the last 3 months, which types of sex have you had?** **If yes, about how often did you or your partner use condoms or barriers for each type of sex?**

| | No | Yes | Always (4 out of 4 times) | Usually (3 out of 4) | Sometimes (2 out of 4) | Occasionally (1 out of 4) | Never (0 out of 4) |
|---|---|---|---|---|---|---|---|
| Had vaginal sex? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Performed anal sex? (top) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Received anal sex? (bottom) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Performed oral sex? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Received oral sex? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**In the past 3 months, have you had <u>unprotected</u> anal or vaginal sex with someone ...**

| | No | Yes | If yes, how many partners? |
|---|---|---|---|
| Who was HIV positive (has HIV)? | ☐ | ☐ | ____ |
| Who was HIV negative? | ☐ | ☐ | ____ |
| Whose HIV status you didn't know? | ☐ | ☐ | ____ |

**Do you have a spouse or main partner?** No ☐ Yes ☐
If yes, for how long? ____ years ____ months
Is your partner: HIV positive (has HIV) ☐ HIV negative ☐ I don't know ☐

**OVER – MORE ON BACK**

**In the past 30 days, have you used any of the following non-injected drugs?** No ☐ Yes ☐

| If yes, have you used the following drugs? | No | Yes | If yes, how many times in the past 30 days? |
|---|---|---|---|
| Crack | ☐ | ☐ | ____ |
| Cocaine | ☐ | ☐ | ____ |
| Heroin | ☐ | ☐ | ____ |
| Amphetamines (speed, crystal) | ☐ | ☐ | ____ |
| Amyl Nitrate (poppers) | ☐ | ☐ | ____ |
| Party drugs (Ecstasy, Special K, GHB) | ☐ | ☐ | ____ |
| Marijuana | ☐ | ☐ | ____ |
| 5 or more alcoholic drinks (in one sitting) | ☐ | ☐ | ____ |
| Other: _____ | ☐ | ☐ | ____ |

**In the past 30 days, have you injected any drugs or medications ?** No ☐ Yes ☐

**If you have injected drugs or medications in the past 30 days, complete this box.**

**In the past 30 days, have you injected any of the following drugs/medications ?**

| | No | Yes | If yes, how many times in the past 30 days? |
|---|---|---|---|
| Heroin | ☐ | ☐ | ____ |
| Cocaine/Crack | ☐ | ☐ | ____ |
| Amphetamines (speed, crystal) | ☐ | ☐ | ____ |
| Steroids | ☐ | ☐ | ____ |
| Insulin | ☐ | ☐ | ____ |
| Hormones | ☐ | ☐ | ____ |
| Prescription drugs (codeine, morphine) | ☐ | ☐ | ____ |
| Other: _____ | ☐ | ☐ | ____ |

| If you have injected drugs in the past 30 days, what kind of needles did you use? | No | Yes |
|---|---|---|
| New | ☐ | ☐ |
| Bleached | ☐ | ☐ |
| Shared (someone used before me) | ☐ | ☐ |
| Shared (someone used after me) | ☐ | ☐ |
| Reused my own | ☐ | ☐ |
| Origin unknown | ☐ | ☐ |

| In the past 30 days, have you shared needles with someone ... | No | Yes |
|---|---|---|
| Who was HIV positive (has HIV) | ☐ | ☐ |
| Who was HIV negative | ☐ | ☐ |
| Whose HIV status you didn't know | ☐ | ☐ |

Have you ever had a test for HIV/AIDS? ☐ Yes ☐ No ☐ Don't Know

What was the result of the HIV test? ☐ Positive (you have HIV) ☐ Negative ☐ Not sure

If you are HIV-positive, how long have you known about your HIV status? _____ years _____ months

If you are HIV-positive, are you receiving medical care for your HIV infection? ☐ Yes ☐ No ☐ Not sure

How many people live in your household, including you? ___

How many years of education have you completed? ___

What is your primary source of household income?

- You (includes Public Assistance) ☐
- Your partner or spouse ☐
- Other family or friends ☐
- Other: specify_____ ☐

What is your annual household income?

- Less than $15,000 ☐
- $15,000 to $24,999 ☐
- $25,000 to $34,999 ☐
- $35,000 to $44,999 ☐
- $45,000 or more ☐

**For agency use only**

Date_____ Staff initial_____

Client code_____

Agency name and region_____

Intervention plan code_____ Check if PHIPP ☐

Site location_____ Country where conducted_____

**Completed by:**

☐ Staff ☐ Client

☐ Without instruction

☐ With instruction in a group

☐ With individual instruction

## Data Collection Forms, Virginia

## ❖ AGENCY NAME ❖
## ONE-TO-ONE INTERVENTION
## RISK ASSESSMENT INSTRUMENT

Date: _____ Time Of Day: _____

Location: _____ Staff: _____

Participant Identifier: [___ ___ ___ ___] [__ __/__ __/__ __]
(1st & 3rd letter of first name + 1st & 3rd letter of last name) (date of birth - Mon/Day/Year)

Gender: ❑ Male ❑ Female ❑ Transgender

| QUESTIONS - ask each question | YES | NO | Ref. | Didn't ask |
|---|---|---|---|---|
| 1. Have you had sex in the last 30 days? *(If no, skip to question 5)* | | | | |
| 2. Have you had sex (within the last 30 days) with anyone who is, or has shot drugs? | | | | |
| 3. Do you have a main or steady sex partner? *(If no, go on to question 4)* | | | | |
| • main partner is a man | | | | |
| • main partner is a woman | | | | |
| • have vaginal sex | | | | |
| • have oral sex | | | | |
| • have anal sex | | | | |
| • main partner shoots drugs | | | | |
| • main partner has sex with other people | | | | |
| 4. Have you had sex with others in the last 30 days? (other than main partner) | | | | |
| • other partners are men | | | | |
| • other partners are women | | | | |
| • have vaginal sex | | | | |
| • have oral sex | | | | |
| • have anal sex | | | | |
| • other partner(s) shoot drugs | | | | |
| 5. Have you consumed alcohol or done any drugs in the last 30 days? | | | | |
| 6. Have you shot drugs in the last 30 days? | | | | |
| • did you share works in the last 30 days? | | | | |

Behavior targeted for change (check one): ❑ vaginal-main partner ❑ anal sex ❑ needle sharing ❑ vaginal-other partner ❑ oral sex ❑ Abstinence ❑ NOT AT RISK

Willingness to engage in program: ❑ Yes ❑ No ❑ Not sure

Time/place for future contact: _____

## ❖ AGENCY NAME ❖
## ONE-TO-ONE INTERVENTION
## PARTICIPANT DEMOGRAPHIC QUESTIONS

1. Relationship Status: ❑ In a committed relationship
   ❑ Not in a committed status

2. Race: (please check only one – if biracial, please check "other" and tell us which racial groups you identify with)

   ❑ African-American/Black ❑ Asian
   ❑ Caucasian/White ❑ American Indian, Aleutian, or Eskimo
   ❑ Native Hawaiian/Other Pacific Islander
   ❑ Other (specify)_____

2a. Are you of Latino or Hispanic Ethnicity?

   ❑ YES ❑ NO

3. How many children do you have? ____

4. Highest grade completed?

   ❑ 8th grade or less
   ❑ Some high school
   ❑ Graduated high school / GED
   ❑ Some college
   ❑ Graduated college
   ❑ Post Graduate School

5. Have you ever been tested for HIV? ❑ YES ❑ NO

**IF YES:**

When were you tested?

❑ Within the last 4 months

❑ between 4 months and one year ago

❑ more than one year ago

Were the results:

❑ Positive

❑ Negative

❑ Don' t Know

# AGENCY NAME ❖

## STAGES OF CHANGE – STAGE DESIGNATION

**1. Use condom last time?** ❑ YES ❑ NO

Participant ID: [ 1st 3rd 1st 3rd ] (1st & 3rd letters of first & last names)

Date of Birth: ___/___/___ Gender: ❑ male ❑ female ❑ transgender

**2. How often use a condom?**

- ❑ All the time } question 3
- ❑ Most of the time
- ❑ About half the
- ❑ Rarely
- ❑ Never

Question 4 →

**3. How long been using a condom all of the time?**

- ❑ 6 months or more } STOP
- ❑ More than 30 days AND less than 6 months STOP
- ❑ Less than 30 days ↓

**4. In the next 6 months, how sure to start using condom all the time?**

- ❑ Very sure will } STOP
- ❑ Kind of sure will
- ❑ Kind of sure won't
- ❑ Very sure won't }

question 5 ↓

**5. How sure from now on to use condom every time?**

- ❑ Very sure will } STOP
- ❑ Kind of sure will
- ❑ Kind of sure won't
- ❑ Very sure won't

Date ___/___/___ Staff initials _____

❖ **AGENCY NAME** ❖

STAGING INSTRUCTIONS

Find the participant's stage by matching his or her responses to the criteria below. Begin with number 1 and stop when you have found the correct stage.

1. **MAINTENANCE**: Uses condoms "all the time" (Q2) for "6 months or more" (Q3).
2. **ACTION**: Uses condoms "all the time" (Q2) for "more than 30 days and less than 6 months" (Q3).
3. **READY FOR ACTION**: Uses condoms "most of the time" or "about half the time" (Q2) for "less the 30 days" (Q3), "very sure will" or "kind of sure will (Q4)
4. **CONTEMPLATION**: Uses condoms "rarely" (Q2) Skip (Q3) "very sure will" or "kind of sure will" (Q4)
5. **PRE-CONTEMPLATION**: Uses condoms "never" (Q2) Skip (Q3) "kind of sure won't" or "very sure won't" (Q4) "kind of sure won't" or "very sure won't" (Q5)

## Data Collection Forms, Maryland

# Youth Program Survey
## Pretest

Your code: _____
Today's date: _____

***Please answer the following items before starting the survey, so we can know more about the population being reached by this program. Remember, you can always choose not to answer a question!***

Are you... ○ Male ○ Female ○ Transgender

How old are you? _____ years

Do you identify yourself as...
○ African-American/Black ○ Hispanic ○ White ○ Asian ○ Other _____

Do you currently live in...
○ Maryland ○ Virginia ○ Washington, D.C.

***The following questions ask what you know about HIV and AIDS. Please answer carefully. For all questions, fill in the bubble for the answer you choose.***

1. Most people with HIV quickly show signs of being sick.
   ○ True ○ False ○ Don't know

2. There is a cure for HIV infection and for AIDS.
   ○ True ○ False ○ Don't know

3. Teenagers are less likely to get AIDS than persons over 20 years old.
   ○ True ○ False ○ Don't know

4. A condom (or other barrier) will always stop HIV.
   ○ True ○ False ○ Don't know

5. Using a condom or other barrier correctly during sex is a good way to keep from getting HIV.
   ○ True ○ False ○ Don't know

6. Only people who have sexual intercourse with gay (homosexual) men get AIDS.
   ○ True ○ False ○ Don't know

7. A person can get HIV by having sex with someone who got it from injecting drugs.
   ○ True ○ False ○ Don't know

8. Can a man give the HIV virus to a woman?
   ○ Yes ○ No ○ Don't know

9. Can a woman give the HIV virus to a man?
O Yes O No O Don't know

10. Can a woman give the HIV virus to another woman?
O Yes O No O Don't know

11. Can a pregnant woman give HIV to her unborn baby?
O Yes O No O Don't know

12. If a woman uses something like the pill or a diaphragm for birth control, will it help protect her from HIV?
O Yes O No O Don't know

13. Oral sex (contact between your mouth and vagina or penis) is just as risky as vaginal sex (penis in vagina) or anal sex (penis in anus or butt) for getting HIV.
O True O False O Don't know

14. The risk of getting HIV increases as the number of sex partners increases.
O True O False O Don't know

15. A person can get HIV from sharing drug injection equipment (like needles) with someone who looks healthy.
O True O False O Don't know

16. Anal sex without a condom is a very risky behavior for getting HIV.
O True O False O Don't know

***The next questions ask what <u>you</u> think about AIDS.***

17. Based on your behavior in the past month, what do you think is your risk for getting HIV?
O no risk O some risk O a lot of risk O extreme risk

18. I am concerned that I could get HIV.
O not at all O a little O somewhat O very much

19. I am concerned that someone I know has HIV or AIDS.
O not at all O a little O somewhat O very much

20. I think that AIDS is a serious problem in my community.
O not at all O a little O somewhat O very much

***The next questions ask how confident you are about practicing safer sex in difficult situations. Please answer every question even if you are not currently sexually active. If you are not currently sexually active, indicate how confident or certain you <u>think</u> you would be in such a situation. "Other barriers" means things like dental dams that, like condoms or rubbers, can block contact with body fluids.***

21. I'm sure that I can suggest using a condom (or other barrier) use with new partners.

| O | O | O | O | O |
|---|---|---|---|---|
| strongly disagree | disagree | unsure | agree | strongly agree |

22. I 'm certain that I would remember to use a condom or other barrier even if I was drinking or using drugs.

| O | O | O | O | O |
|---|---|---|---|---|
| strongly disagree | disagree | unsure | agree | strongly agree |

23. I'm certain that I will practice safer sex (like using a condom or other barrier) when I am with a regular partner.

| O | O | O | O | O |
|---|---|---|---|---|
| strongly disagree | disagree | unsure | agree | strongly agree |

24. I feel that safer sex can still be satisfying to me.

| O | O | O | O | O |
|---|---|---|---|---|
| strongly disagree | disagree | unsure | agree | strongly agree |

25. I find it difficult to have intercourse with a condom (or other barrier).

| O | O | O | O | O |
|---|---|---|---|---|
| strongly disagree | disagree | unsure | agree | strongly agree |

26. I'm certain that I will have sex with a condom or barrier when I'm with a non-regular sex partner (anyone other than my main sex partner).

| O | O | O | O | O |
|---|---|---|---|---|
| strongly disagree | disagree | unsure | agree | strongly agree |

27. I'm certain that I know how to use a condom (or other barrier) correctly.

| O | O | O | O | O |
|---|---|---|---|---|
| strongly disagree | disagree | undecided | agree | strongly agree |

28. Have you ever been tested for HIV?

O Yes O No O I don't remember/don't know

29. If you have been tested for HIV, what kind of test was it?

O Blood test O Oral test O I don't know

30. If you have been tested for HIV, did you find out your test result?

O Yes O No O I don't remember

31. If you have never been tested for HIV, what are your reasons? *You can check more than one option.*

- ❍ I don't think I have HIV
- ❍ I'm afraid to find out the results
- ❍ I don't know where to get tested
- ❍ I'm afraid someone will find out I got tested
- ❍ I just haven't gotten around to it
- ❍ I'm afraid of the test itself
- ❍ I'm afraid of needles
- ❍ I'm not doing anything risky that could give me HIV
- ❍ I don't have the money or resources, like transportation, to get to a testing site
- ❍ Other (fill in your own reason) _____

32. If you have never been tested for HIV, do you now intend to do so?

❍ Yes, definitely ❍ Yes, maybe ❍No, not really ❍ Definitely not

***The next questions ask about what your friends think and do.***

33. My friends practice safer sex.

| ❍ | ❍ | ❍ | ❍ | ❍ |
|---|---|---|---|---|
| strongly disagree | disagree | unsure | agree | strongly agree |

34. My friends feel that it is too much trouble to use condoms or barriers during sex.

| ❍ | ❍ | ❍ | ❍ | ❍ |
|---|---|---|---|---|
| strongly disagree | disagree | unsure | agree | strongly agree |

35. Most of my friends think that practicing safer sex can lower the risk of AIDS.

| ❍ | ❍ | ❍ | ❍ | ❍ |
|---|---|---|---|---|
| strongly disagree | disagree | unsure | agree | strongly agree |

*For these next questions, "people who are important to me" means* ***people whose ideas or beliefs about sex are important to you****. These could be friends, brothers or sisters, parents, or anyone else as long as what they think and believe about sex matters to you. Keep this in mind as you answer the questions.*

36. Most people who are important to me think I should use condoms or other barriers during sex.

❍ very true ❍ somewhat true ❍ unsure ❍ not really true ❍ not true at all

37. Most people who are important to me think that I should not have sexual intercourse at all at this time in my life.

❍ very true ❍ somewhat true ❍ unsure ❍ not really true ❍ not true at all

***The following items ask if you know where you or other people can get services or help related to HIV and AIDS.***

38. I know where I can go to get anonymous testing for HIV.
    O Yes O No

39. I know where I can get condoms.
    O Yes O No

40. I know where I can go or call to find out more information about HIV.
    O Yes O No

41. I know where people with HIV or AIDS can go to get help, like getting drugs to treat HIV.
    O Yes O No

***The next questions ask about sexual and drug-related behaviors that may expose a person to HIV. Please remember that answering these questions is completely voluntary and that your answers cannot be linked to your real name or identity.***

42. Have you ever had vaginal sex (penis in vagina) with another person?
    O Yes O No
    If you said **yes**, how often did this happen in the last 3 months? _____
    How many different persons did this happen with? _____
    How often during these experiences did you use a condom or other barrier?
    O Always O Sometimes O Never

43. Have you ever had anal sex (penis in anus or butt) with another person?
    O Yes O No
    If you said **yes**, how often did this happen in the last 3 months? _____
    How many different persons did this happen with? _____
    How often during these experiences did you use a condom or other barrier?
    O Always O Sometimes O Never

44. Have you ever had oral sex (contact between your mouth and vagina or penis) with another person?
    O Yes O No
    If you said **yes**, how often did this happen in the last 3 months? _____
    How many different persons did this happen with? _____
    How often during these experiences did you use a condom or other barrier?
    O Always O Sometimes O Never

45. Have you ever used drugs of any kind that you injected using a needle?
    O Yes O No
    If you said **yes**, how often did this happen in the last 3 months? _____
    How often during these experiences did you use a new needle that no one else had used, or clean the needle that you used?
    O Always O Sometimes O Never

46. Have you ever had sexual contact with another person while you were drinking alcohol or using other drugs?

O Yes O No

If you said **yes**, how often did this happen in the last 3 months? _____

How many different persons did this happen with? _____

***You're done! Thanks very much for your time and help. Make sure you didn't write any personal identification on the questionnaire. Seal the questionnaire in the envelope and return it to the staff.***

# About this form:

The Maryland State Health Department plans and funds HIV prevention programs across the state. In order to make these programs better, we need your help.
The following questionnaire will help us better understand:

- **who** benefits from HIV prevention programs;
- **how** to improve these prevention programs.

This questionnaire is completely anonymous. No one will know that this form belongs to you. Some of the questions may be sensitive. You may choose not to answer any question.

If you have any questions, please ask your group facilitator.

# How to complete this form:

**MARKING INSTRUCTIONS**

- **Use a No. 2 pencil or a blue or black ink pen only.**
- **Do not use pens with ink that soaks through the paper.**
- **Make solid marks that fill the response completely.**
- **Make no stray marks on this form.**

**CORRECT:** ● **INCORRECT:** ⊘ ⊗ ◒ ◔

## If you have any questions about HIV/AIDS or would like information about testing...

## Please call: 1-800-638-6252

# PARTICIPANT FORM

| TODAY'S DATE | Month | Day | Year |
|---|---|---|---|
| | | | |

| DATE OF BIRTH | Month | Day | Year |
|---|---|---|---|
| | | | |

**1.** What is your sex?
Ⓜ Male Ⓕ Female

If female, are you pregnant?
Ⓨ Yes Ⓝ No Ⓓ Don't Know

**2.** Do you consider yourself Hispanic/Latino?
Ⓨ Yes Ⓝ No

**3.** What is your race? (Mark all that apply)
Ⓐ African American or Black
Ⓝ North American Indian or Alaska Native
Ⓒ Central or South American Indian
Ⓟ Asian or Pacific Islander
Ⓦ White
Ⓞ Other _____

**4.** **IN THE PAST 12 MONTHS:** Which of the following statements were true for you?

| **I have had:** | **(Mark Yes or No)** | |
|---|---|---|
| a. vaginal sex. | Ⓨ Yes | Ⓝ No |
| b. anal sex with a man. | Ⓨ Yes | Ⓝ No |
| c. oral sex with a man. | Ⓨ Yes | Ⓝ No |
| d. anal sex with a woman. | Ⓨ Yes | Ⓝ No |
| e. oral sex with a woman. | Ⓨ Yes | Ⓝ No |

**5.** In the past 12 months, with how many different people have you had sex? _____
(vaginal, anal or oral)

**6.** In the past 12 months, how often did you or your partner use condoms/barriers?
Ⓐ Always
Ⓤ Usually
Ⓢ Sometimes
Ⓝ Never
Ⓓ Does Not Apply

**7.** **IN THE PAST 12 MONTHS:** Which of the following statements are true for you?

a. I have had sex while high on drugs or alcohol.
Ⓨ Yes Ⓝ No Ⓓ Don't Know

b. I have used a needle used by another person for drugs, vitamins, steroids, body piercing or tattooing.
Ⓨ Yes Ⓝ No Ⓓ Don't Know

c. I have injected drugs.
Ⓨ Yes Ⓝ No

d. I have had sex with a person who shares needles.
Ⓨ Yes Ⓝ No Ⓓ Don't Know

e. I have had sex with a person who has HIV or AIDS.
Ⓨ Yes Ⓝ No Ⓓ Don't Know

f. I have given or received sex for drugs, shelter or money.
Ⓨ Yes Ⓝ No

g. I have had a sexually transmitted disease (STD).
Ⓨ Yes Ⓝ No Ⓓ Don't Know

**8.** When was the last time you were tested for HIV?
Ⓦ Within the past 12 months
Ⓜ More than 12 months ago
Ⓝ Never been tested

**9.** What was the test result?
Ⓟ Positive
Ⓝ Negative
Ⓓ Don't Know

**FORM A**

version 2.1 4/2001

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# Información sobre este formulario:

El Departamento de Salud del Estado de Maryland, planifica y crea programas de prevención para el VIH. Para mejorar estos programa necesitamos su ayuda.

El siguiente cuestionario puede ayudarnos a entender mejor:

- **quiénes** se benefician de estos programas de prevención;
- **cómo** podemos mejorar estos programas.

Este cuestionario es completamente ANÓNIMO. Nadie sabrá que esta información le pertenece a usted. Algunas de las preguntas son muy personales. Si así lo desea, usted puede elegir no contestar ninguna pregunta.

Si tiene alguna pregunta, por favor hable con el facilitador de su grupo.

# Cómo completar este formulario:

**INSTRUCCIONES**

- **Únicamente use lápiz # 2 o bolígrafo azul o negro.**
- **No use bolígrafos que puedan gotear en el papel.**
- **Haga marcas sólidas que llenen la respuesta completamente.**
- **No haga líneas o marcas en este formulario.**

**CORRECTO:** ● **INCORRECTO:** ✓ ✗ ◒ ◔

Si usted tiene alguna pregunta sobre el VIH/SIDA o si desea información sobre el examen...

Por favor llame al: 1-800-553-3140

# Formulario para Participantes Hispanos/Latinos

| | MES | DIA | AÑO |
|---|---|---|---|
| DIA DE HOY | | | |
| FECHA DE NACIMIENTO | | | |

**1.** ¿Cuál es su sexo?
Ⓕ Femenino Ⓜ Masculino

Si es mujer, ¿está embarazada?
Ⓢ Si Ⓝ No ⓃⓈ No sé

**2.** ¿Se considera usted Hispano(a)/Latino(a)?
Ⓢ Si Ⓝ No

**3.** País de origen:_____

**4.** ¿Cuál es su raza? (Por favor marque todas las que correspondan)
Ⓝ Negro
Ⓐ Asiático o de las Islas del Pacífico
Ⓘ Indígena Norte/Centro/Sud-Americano
Ⓑ Blanco
Ⓞ Otro: _____

**5.** ¿Hace cuánto tiempo vive en los Estados Unidos?
_____

**6.** Usted tiene pareja en...
Ⓛ Los Estados Unidos
Ⓢ Su país
Ⓝ No tiene pareja

**Las siguientes preguntas opcionales son muy íntimas y personales. Si lo desea, NO LAS CONTESTE.**

**7. DURANTE LOS ULTIMOS 12 MESES...**
Yo he tenido relaciones sexuales (por la vagina, por el ano/recto o por la boca/oral)...

con un hombre Ⓢ Si Ⓝ No
con una mujer Ⓢ Si Ⓝ No

**8.** ¿Con cuántas personas ha tenido relaciones sexuales durante los últimos 12 meses? _____

**9.** Cuando ha tenido relaciones sexuales durante los últimos 12 meses, ¿cuántas veces usted o su pareja ha/han utilizado condones?
Ⓢ Siempre Ⓐ Algunas veces Ⓝ No Aplica
Ⓐ Usualmente Ⓝ Nunca

**10. DURANTE LOS ULTIMOS 12 MESES...**
**¿Cuáles de las siguientes frases son ciertas?**

a. Tuve relaciones sexuales luego de haber tomado cerveza, vino u otras bebidas alcohólicas. Ⓢ Si Ⓝ No

b. Tuve relaciones sexuales después de haber usado drogas ilegales. Ⓢ Si Ⓝ No ⓃⓈ No sé

c. Me inyecté drogas ilegales. Ⓢ Si Ⓝ No

d. Utilizé agujas o jeringuillas usadas por otra/s persona/s para inyectarme drogas, vitaminas, esteroides, hacerme tatuajes o agujeritos. Ⓢ Si Ⓝ No ⓃⓈ No sé

e. Tuve relaciones sexuales con una persona que comparte agujas. Ⓢ Si Ⓝ No ⓃⓈ No sé

f. Tuve relaciones sexuales con una persona que tiene VIH/SIDA. Ⓢ Si Ⓝ No ⓃⓈ No sé

g. Tuve relationes sexuales con alguien a cambio de dinero, drogas o alojamiento. Ⓢ Si Ⓝ No

h. Tuve una enfermedad de transmisión sexual/venérea.
Ⓢ Si Ⓝ No

**11.** ¿Cuándo fue la última vez que se hizo la prueba/el examen del VIH?
Ⓔ En los últimos 12 meses
Ⓗ Hace más de 12 meses
Ⓝ Nunca

Si contesta Sí,¿dónde?_____

¿Cuál fue su resultado? Ⓟ Positivo
Ⓝ Negativo
Ⓝ No sé

**FORM C**

version 2.1 4/2001

## Data Collection Form, New Jersey

# MULTI-SESSIONAL INTERVENTION CLIENT INTAKE DATA

[redacted]

Agency name and location _____

Client identification # | | | | | | | |

Encounter date: ____/____/2000 ☐ New ☐ Update

Birth date: ____/____/____ Age ☐☐

PREVENTION PROJECT # 0 0 0 0 ☐☐

AGENCY CTS # 0 0 0 ☐☐☐

**A Population reached [Check all that apply]**

**Primary [Must check at least one category]**

1 ☐ MSM
2 ☐ MSM/IDU
3 ☐ IDU
4 ☐ Heterosexual female
5 ☐ Heterosexual male
6 ☐ Perinatal
7 ☐ General public

**Additional information**

8 ☐ Youth
9 ☐ Non-IDU substance user
10 ☐ Incarcerated
11 ☐ Homeless
12 ☐ Sex worker
13 ☐ Other_____

**B How did you find out about this program?**

**[Check all that apply]**

1 ☐ Friend
2 ☐ Program outreach worker
3 ☐ Word of mouth
4 ☐ Internal/this agency
5 ☐ Agency program literature/flyer
6 ☐ Other program literature/flyer
7 ☐ External/other agency/provider
8 ☐ Counseling & testing site
9 ☐ Part of parole package
10 ☐ Hotline
11 ☐ Support group
12 ☐ Rape crisis
13 ☐ Other (specify)_____

**C Ethnicity [For statistical purposes, Hispanic & Other Origins are not considered races.]**

**C1 Are you of Hispanic origin? [Check one only]**

1 ☐ Yes [go to C1a]
2 ☐ No [go to C2]
8 ☐ Don't know
9 ☐ Not stated

**C1a Do you consider yourself? [Check one only]**

1 ☐ Mexican
2 ☐ Puerto Rican
3 ☐ Cuban
4 ☐ Dominican
5 ☐ Other Central or South American
6 ☐ Other Hispanic
[go to D]

**C2 Do you consider yourself of other ethnic origin? [Check one only]**

1 ☐ Yes [go to C2a]
2 ☐ No [go to C]
8 ☐ Don't know [go to D]
9 ☐ Not stated [go to D]

**C2a Do you consider yourself? [Check one only]**

1 ☐ Haitian
2 ☐ Jamaican
3 ☐ Guyanian
4 ☐ Other Non-Hispanic Carribbean
5 ☐ Other Non-Hispanic Central or South American
6 ☐ Unknown
7 ☐ Other_____
[go to D]

**D Race**

Of the following, which race or races do you consider yourself to be?
**[Check all that apply]**

1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
4 ☐ Asian
5 ☐ Native Hawaiian or Other Pacific Islander
6 ☐ Other_____
9 ☐ Not Classifiable or Unknown

**E What language(s) do you most understand for speaking and/or writing?**

| Language | A. Speak | B. Read | C. Don't kno | D. Not stated |
|---|---|---|---|---|
| 1 English | 1 ☐ | 1 ☐ | 1 ☐ | 1 ☐ |
| 2 Spanish | 2 ☐ | 2 ☐ | 2 ☐ | 2 ☐ |
| 3 French/Creole | 3 ☐ | 3 ☐ | 3 ☐ | 3 ☐ |
| 4 Other (specify) | 4 ☐ | 4 ☐ | 4 ☐ | 4 ☐ |

**F Sex [Check one only]**

1 ☐ Male
2 ☐ Female
3 ☐ Transgender

**G Do you consider yourself? [Check one only]**

1 ☐ Heterosexual (straight)
2 ☐ Gay
3 ☐ Lesbian
4 ☐ Bisexual
5 ☐ Uncertain/questioning
9 ☐ Not stated

**H HIV self-assessed risk**

What are your chances of getting infected with HIV, the virus that causes AIDS? [Check one only]

1 ☐ High
2 ☐ Medium
3 ☐ Low
4 ☐ None
8 ☐ Don't know
9 ☐ Not stated

Do not read below. Record if the client volunteers.
5 ☐ Already have HIV

**I Client risk factors [Check all that apply]**

**Main risks**

1 ☐ Injection drug user, especially one not in treatment.
2 ☐ Person who repeatedly becomes infected with sexually transmitted diseases (STDs).
3 ☐ Sex partner, especially one who has unprotected sex with IDU, bisexual men, and/or any partners of unknown status.
4 ☐ Person who exchanges sex for resources or person providing resources for sex.
5 ☐ Pregnant woman, particularly one not in prenatal care.

**Additional risks/information**

6 ☐ Non-injection drug user, especially one not in treatment.
7 ☐ Alcohol user, especially one not in treatment.
8 ☐ Youth in high risk situation.
☐ Runaway
☐ Juvenile offender
☐ Out of school
☐ Other_____
9 ☐ Inmate or recently released resident of criminal justice facilities.
10 ☐ Person who may be in the "window period" of infection with HIV and the development of antibodies, usually 6-12 weeks.
11 ☐ HIV infected person unable to obtain supportive services.
12 ☐ Person who has recently learned s/he is infected with HIV and is experiencing acute mental health stress.
13 ☐ Person who is experiencing other health and non mental health related stress.
14 ☐ Homeless
15 ☐ Other_____

**J Initial stage of change [Check one only]**

1 ☐ Pre-contemplation: Client does not intend to make a change in his/her behavior in the near future. Client may be unaware of his/her risk or in denial.
2 ☐ Contemplation: Client has begun to think seriously about changing his/her behavior. S/he knows that a problem exists and is considering taking action.
3 ☐ Preparation: Client has made a decision to begin practicing safer behavior and may have begun the process, but my have been doing it inconsistently or for a short time.
4 ☐ Action: Client has modified his/her behavior, experiences or environment to overcome problems. Behavior change is relatively recent (30 days-6 months).
5 ☐ Maintenance: Client is working to prevent relapse and maintain the behavior change over a long time period (more than 6 months).
6 ☐ Don't know

Initials of the agency representative completing this form: ☐☐☐

New Jersey Department of Health and Senior Services
Division of AIDS Prevention and Control
PO Box 363, Trenton, NJ 08625-0363

Updated 07/31/2000

## INSTRUCTIONS FOR THE MULTI-SESSIONAL INTERVENTION CLIENT INTAKE DATA COLLECTION FORM

**Purpose**

The purpose of this form is to provide a summary of the client's demographic profile and to serve as a link to HE/RR and/or PCM encounter form(s).

**General Instructions**

This form needs to be completed once when the client initially enrolls in an HE/RR cycle and/or PCM sessions.

**Specific Instructions**

Agency name and location — Print the name of the agency providing the service. Example: Old Barney Lighthouse Agency - Barnegat Light

Client Identification # [ ][ ][ ][ ][ ][ ][ ][ ] Generate and fill in the client's eight-digit identification number as follows:

First initial of the client's **first** name+ Third initial of the client's **first** name+ First initial of the client's **last** name+ Third initial of client's last name + client's birth month and the last two digits of the birth year

Example: If the client is James Smith who was born on January 1, 2000, then his client ID would be: [J][M][S][I][0][1][0][0]

Anita Doe who was born on December 16, 1973 would have a client ID [A][I][D][E][1][2][7][3]

What if the client has a very short name? Then fill in the blanks with the letter, "Q".

Example: An Li who was born on February 1, 1950 would have the following client ID: [A][Q][L][Q][0][2][5][0]

Encounter date __/__/ 2000 Fill in the date when the encounter occurred. Example: 04/21/2000

Birth Date: __/__/____

Enter the client's date of birth. In the first section, fill in the two-digit number (01 to 12) that corresponds to the month that the client was born. In the second section, fill in the two-digit number (01 to 31) that corresponds to the day that the client was born. In section three, fill in the complete year that the client was born.

Age [ ] Fill in the client's age at his/her last birthday. This and the birth date serve as a check for the other item.

Example: "Anna Doe" who was born on December 16, 1973 would be [2][6]

[ ] [redacted] [ ] [redacted]

This item pertains to data entry issues. It will be completed by the NJDHSS at the time of data entry and should be left blank.

[ ] [redacted] [ ] [redacted]

This item should be checked to clarify whether this is a new form or an update to a previously submitted form.

Prevention project number: [ ][ ][ ][ ][ ][ ] Fill in your assigned project number. Example: [0][0][0][0][2][6]

Agency CTS# [ ][ ][ ][ ][ ][ ] Fill in your agency's assigned Counseling and Testing number. Example [0][0][0][1][2][3]

**A Population reached [Check all that apply]**

Enter a check in the box(es) to the left of the word/phrase that best characterizes the client population(s) you reached.

**Primary: You must check one category here.**

MSM: Men who report sexual contact with other men or with both men and women.

MSM/IDU: Men who report **both** sexual contact with other men **and** injection drug use.

IDU: People who are at risk for HIV infection through the use of equipment to inject drugs (e.g. syringes, needles, cookers, spoons, etc.).

Heterosexual female: Women who report heterosexual contact with a male or are at increased risk for HIV infection (e.g., sex with an injection drug user or a person known to be HIV-positive or to have AIDS, or unprotected sex with a male partner of unknown status).

Heterosexual male: Men who report heterosexual contact with a female or are at increased risk for HIV infection (e.g., sex with an injection drug user or a person known to be HIV-positive or to have AIDS, or unprotected sex with a female partner of unknown status).

Perinatal: Women who have HIV or are at risk for becoming infected and are pregnant (of childbearing age) and, thus, at risk of transmitting HIV to their infant(s).

General public: Any group whose behavior does not fall in the above categories yet puts them at high risk for HIV infection.

**Additional information:** These are additional descriptive categories of populations reached.

Youth: Persons between 13 and 24 years, who are either not yet patterned in the high risk behavior of the other priority populations or are engaging in behaviors that put them at risk for HIV infection.

Non-IDU: Persons who are at risk for HIV infection through the use of drugs that do not involve any injection equipment. These substances are primarily crack, alcohol, methamphetamine and/or "crystal", which are associated with increased risk for HIV and AIDS (i.e., impairments in judgement that result in risky behavior such as unprotected sex). These substances may also be smoked or sniffed/snorted. Other substances may also include LSD, amphetamine, nitrates/poppers, Ecstasy and tranquilizers.

Homeless: Individuals who lack a fixed, regular and adequate night time residency or resides in a shelter designed to provide temporary living accomodations. This category also includes persons who face imminent eviction (within a week) from a private dwelling or institution and who have no subsequent residence or resources to obtain housing.

Incarcerated: Men, women and youth in and out of prisons, jails, detention, alternative sanctions, mutual assistance programs (MAPs), in halfway institutions and/or on parole.

Sex worker: Person who is at risk for HIV infection through exchanging sex for resources (e.g., food, shelter, drugs, etc.) or a person who provides resources in exchange for sex.

Other: A specific risk population that has not been described in the above categories (e.g., migrant worker, lesbian).

Example: The client is a 19-year old pregnant woman who injects drugs.

| | |
|---|---|
| [ ] MSM | [X] Youth |
| [ ] MSM/IDU | [ ] Non-IDU substance user |
| [X] IDU | [ ] Incarcerated |
| [ ] Heterosexual female | [ ] Homeless |
| [ ] Heterosexual male | [ ] Sex worker |
| [ ] Perinatal | [ ] Other_____ |
| [ ] General public | |

Example: The client is a heterosexual male who uses alcohol.

| | |
|---|---|
| [ ] MSM | [ ] Youth |
| [ ] MSM/IDU | [X] Non-IDU substance user |
| [ ] IDU | [ ] Incarcerated |
| [ ] Heterosexual female | [ ] Homeless |
| [X] Heterosexual male | [ ] Sex worker |
| [ ] Perinatal | [ ] Other_____ |
| [ ] General public | |

Example: The client is a male who engages in sex with other men.

| | |
|---|---|
| [X] MSM | [ ] Youth |
| [ ] MSM/IDU | [ ] Non-IDU substance user |
| [ ] IDU | [ ] Incarcerated |
| [ ] Heterosexual female | [ ] Sex worker |
| [ ] Heterosexual male | [ ] Other_____ |
| [ ] Perinatal | |
| [ ] General public | |

Example: The client is a 15-year old incarcerated male.

| | |
|---|---|
| [ ] MSM | [X] Youth |
| [ ] MSM/IDU | [ ] Non-IDU substance user |
| [ ] IDU | [X] Incarcerated |
| [ ] Heterosexual female | [ ] Homeless |
| [X] Heterosexual male | [ ] Sex worker |
| [ ] Perinatal | [ ] Other_____ |
| [ ] General public | |

**B How did you find out about this program?** **[Check all that apply]**

Enter a check in the box(es) to the left of each source through which the client hear about the program.

| | | | | | |
|---|---|---|---|---|---|
| 1 | X | Friend | 8 | | Hotline |
| 2 | | Neighborhood group or church | 9 | | External/other agency/provider |
| 3 | | Program outreach worker | 10 | | Part of a parole package |
| 4 | | Word of mouth | 11 | | Pastoral/spiritual |
| 5 | | Internal/this agency | 12 | | Support group |
| 6 | | Agency program literature/flyer | 13 | | Rape crisis |
| 7 | | Other program literature/flyer | 14 | | Other_____ |

Example: Client heard about program from a friend.

**C Ethnicity** - refers to the national or cultural group with which one identifies by virtue of one's ancestry. Ethnicity may span more than one racial category, as is the case with Hispanics. For the purposes of this study, Hispanic is an ethnic rather than a racial identification since one can be Hispanic and White or Hispanic and Black, etc.

Read the question. Then read the options "Yes" or "No". Do not read options "Don't know" or "Not stated". Check the box next to the appropriate answer.

If the client answers "Yes" follow with **C1a.**
If the client answers "No", skip to question **C2.**
If respondent doesn't know, then check box 8 and follow with question **C2.**
If respondent refuses ("Not stated"), then check box 9 and follow with question **C2.**

Example: Are you of Hispanic origin?

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | X | Yes | [go to C1a] | 8 | | Don't know | [Go to C2] |
| 2 | | No | [Go to C2] | 9 | | Not stated | [Go to C2] |

Since the client has responded that s/he is of Hispanic origin, go to **C1a.** Read the question and choices 1 through 6. Record only **one answer from the respondent.**

**C1a [If yes],** Do you consider yourself

**[Check one only]**

| | | | | | |
|---|---|---|---|---|---|
| 1 | | Mexican | 4 | | Dominican |
| 2 | X | Puerto Rican | 5 | | Other Central and South American |
| 3 | | Cuban | 6 | | Other Hispanic (Go to D) |

The client has responded s/he is Puerto Rican. The interviewer moves on to subsection D.

If the client is not of Hispanic origin, then read question **C2** and options "Yes" and "No". Do not read options "Don't know" or "Not stated". Check the box next to the appropriate answer.

If the client answers "Yes", then follow with **C2a.**
If the client answers "No", then go to question **D.**
If the client doesn't know, then check box 8 and follow with question **D.**
If the client refuses to answer, then check box 9 and follow with question **D.**

If the client considers him/herself to be of other ethnic origin and answered "yes" to question **C2**, then read question **C2a** and choices 1 through 5. Record only one answer from the client. Check the box to the left of the selection that best describes his/her ethnicity. Do not read answer options 6 or 7.

Example: The client has responded "no" to question **C1.** The client has responded s/he is not of Hispanic origin. S/he has stated that s/he is Haitian.

**C2a [If yes],** Do you consider yourself **[Check one only]**

| | | | | | |
|---|---|---|---|---|---|
| 1 | X | Haitian | 5 | | Other Non-Hispanic Central or South American |
| 2 | | Jamaican | 6 | | Other |
| 3 | | Guyanian | 7 | | Unknown |
| 4 | | Other Non-Hispanic Carribbean | | | |

**D Race** Check one or more races to indicate what the person considers him/herself to be. Race refers to the "genetically transmitted physical characteristics" like skin color, which, more or less, distinguish a human population as a distinct group (Webster's Dictionary). The following racial categories are described immediately below:

White: A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

Black or African American: A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American".

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Other: For any person who isn't described in any of the above categories. Please specify this Other Race.

Not Classifiable or Unknown: For any person who isn't sure of his/her race (e.g., an Hispanic client who is unaware of his/her race).

Example: The client identifies him/herself to be Black.

| | | |
|---|---|---|
| 1 | | White |
| 2 | X | Black or African American |
| 3 | | American Indian or Alaska Native |
| 4 | | Asian |
| 5 | | Native Hawaiian or Other Pacific Islander |
| 6 | | Other_____ |
| 9 | | Not Classifiable or Unknown |

What if the client is multi-racial? Then check all categories that apply.

| | | |
|---|---|---|
| 1 | | White |
| 2 | X | Black or African American |
| 3 | X | American Indian or Alaska Native |
| 4 | X | Asian |
| 5 | | Native Hawaiian or Other Pacific Islander |
| 6 | | Other_____ |
| 9 | | Not Classifiable or Unknown |

Example: The client identifies herself to be Filipino, African American and Eskimo.

Example: The client identifiers herself to be Chamorro.

| | | |
|---|---|---|
| 1 | | White |
| 2 | | Black or African American |
| 3 | | American Indian or Alaska Native |
| 4 | | Asian |
| 5 | X | Native Hawaiian or Other Pacific Islander |
| 6 | | Other_____ |
| 9 | | Not Classifiable or Unknown |

Example: The client identifies himself to be Korean and White.

| | | |
|---|---|---|
| 1 | X | White |
| 2 | | Black or African American |
| 3 | | American Indian or Alaska Native |
| 4 | X | Asian |
| 5 | | Native Hawaiian or Other Pacific Islander |
| 6 | | Other_____ |
| 9 | | Not Classifiable or Unknown |

**E Language(s) most understood for speaking and/or reading?**

| LANGUAGE | A. Speak | B. Read | D. Don't know | E. Not stated |
|---|---|---|---|---|
| 1 [X] English | 1 [X] | 1 [ ] | 8 [ ] | 9 [ ] |
| 2 [X] Spanish | 2 [X] | 2 [X] | 8 [ ] | 9 [ ] |
| 3 [ ] French/Creole | 3 [ ] | 3 [ ] | 8 [ ] | 9 [ ] |
| 4 [ ] Other | 4 [ ] | 4 [ ] | 8 [ ] | 9 [ ] |

The client speaks both English and Spanish fluently and uses them equally for speaking, but does not read in English.

Ask the question "What language(s) do you use or understand the most for speaking and/or reading?" Then, read language choices 1 to 3. Let the client select one of these. This is the client's primary language. Ask the client if s/he uses or understands his/her primary language "the most" for speaking and/or reading. Check the appropriate box(es) under the columns to the right.

If the client says s/he uses or understands his/her primary language "the most" for speaking and reading, then STOP. Go to item F.
If the client says s/he uses or understands his/her primary language "the most" for either speaking or reading, proceed to the next language until the client identifies for each function a language that s/he uses or understands "the most".
If the client cannot select a primary language among the first three options, then ask the client if there is some "other" language not on the list.
In item 4, "Other", ask the client to specify his/her answer on the line provided. Then ask the client if that is the language s/he understands "the most" for speaking and/or reading. Check the appropriate boxes.
If the client is equally fluent in both English and another language, then ask about speaking and reading in both.

**F Sex [By observation]**

1 [ ] Male
2 [X] Female
3 [ ] Transgender

Check the box next to the selection which best describes the biological sex of the client. **Note:** Transgender is also referred to as transsexual". This term refers to individuals who have undergone or are undergoing a physical or psychological sex change. Typically, this designation is used when reported by the client.
Example: The client is female.

**G Do you consider yourself [check one only]**

1 [ ] Heterosexual (Straight)
2 [ ] Gay
3 [ ] Lesbian
4 [X] Bisexual
5 [ ] Uncertain
6 [ ] Other_____

Read the question. Record the client's answer by checking the box next to the one response that best describes the way the client identifies his/her sexual orientation.

Example: The client describes him/herself as Bisexual.

**H HIV Self Assessed Risk**

This question applies to ALL clients. Read the question. Then, read choices 1 to 4. Do not read the answers "Already have", "Don't know", or "Not stated". Check the appropriate box for the client's answer. Check 5, 8 or 9 only if the client voluntarily reveals that s/he is HIV positive, doesn't know or does not state an answer.

**I Client Risk Factors [check all that apply]**

Enter a check in the box(es) to the left of the statements which best describe the behavior(s) that the client engages in, placing him/her at risk of acquiring or transmitting HIV infection.

**J Initial Stage of Change [Check one only]**

Based on the client's behaviors, check the box next to the stage that best fits the client.
Example: The client typically shares needles when injecting drugs; however, s/he is considering a entering drug treatment but has not taken any actions.

1 [ ] Pre-contemplation
2 [X] Contemplation
3 [ ] Preparation
4 [ ] Action
5 [ ] Maintenance
8 [ ] Don't know

**Contact Initials: [Representative]**

Ex. Suppose the agent is Patricia Anne Jones [P][A][J]

Enter the first initial of the first, middle and last name of the agency representative completing the form. If the person does not have a middle name, put a dash in the middle column instead.

## Client Code Sign-In Sheet, Maryland

# Sign- In Sheet

Vendor _____ Project _____

Facilitator _____ Date: ____/____/____ Time _____

| | Initials | Age Group | Sex | Are you Hispanic/Latino? | What is your race? (Mark all that apply) |
|---|---|---|---|---|---|
| 1 | | 0-13 14-19 20-29 30+ | | | |
| 2 | | 0-13 14-19 20-29 30+ | | | |
| 3 | | 0-13 14-19 20-29 30+ | | | |
| 4 | | 0-13 14-19 20-29 30+ | | | |
| 5 | | 0-13 14-19 20-29 30+ | | | |
| 6 | | 0-13 14-19 20-29 30+ | | | |
| 7 | | 0-13 14-19 20-29 30+ | | | |
| 8 | | 0-13 14-19 20-29 30+ | | | |
| 9 | | 0-13 14-19 20-29 30+ | | | |
| 10 | | 0-13 14-19 20-29 30+ | | | |
| 11 | | 0-13 14-19 20-29 30+ | | | |
| 12 | | 0-13 14-19 20-29 30+ | | | |
| 13 | | 0-13 14-19 20-29 30+ | | | |
| 14 | | 0-13 14-19 20-29 30+ | | | |
| 15 | | 0-13 14-19 20-29 30+ | | | |

- Use a No. 2 pencil or a blue or black ink pen only.
- Do not use pens with ink that soaks through the paper.
- Make solid marks that fill the response completely.
- Make no stray marks on this form.

CORRECT: ● INCORRECT: ⊘ ⊠ ◒ ◔

**RACE RESPONSES**

AA = African American or Black
AI = American Indian or Native Alaskan
AP = Asian or Pacific Islander
W = White
O = Other